



Name	Date
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My Symptom Check-In

Please complete before seeing the nurse or GP

Please tell us how you have been feeling over the past 24 hours. Rate each symptom on a scale from 0 to 10.

0 means that the symptom is no problem at all. **10** means that it is a big problem and very hard to manage.

	Circle a number for each symptom											
Symptom	0	1	2	3	4	5	6	7	8	9	10	
Pain	0	1	2	3	4	5	6	7	8	9	10	
Tiredness	0	1	2	3	4	5	6	7	8	9	10	
Drowsiness	0	1	2	3	4	5	6	7	8	9	10	
Nausea (feeling sick in the stomach)	0	1	2	3	4	5	6	7	8	9	10	
Appetite	0	1	2	3	4	5	6	7	8	9	10	
Shortness of Breath	0	1	2	3	4	5	6	7	8	9	10	
Constipation	0	1	2	3	4	5	6	7	8	9	10	
Sleep problems	0	1	2	3	4	5	6	7	8	9	10	
Depression (feeling sad)	0	1	2	3	4	5	6	7	8	9	10	
Anxiety (feeling nervous)	0	1	2	3	4	5	6	7	8	9	10	
Wellbeing (how you feel overall)	0	1	2	3	4	5	6	7	8	9	10	
Do you spend 50% or more of the day in a bed or chair?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure											
Have you been to hospital or the emergency department since you last completed this My Symptom Check-In form?	<input type="checkbox"/> Yes <input type="checkbox"/> No											