MARGARET MARY HEALTH

P.O. Box 226 • 321 Mitchell Avenue
Batesville, IN 47006
Phone: 812.934.6624

DISTRESS MANAGEMENT SURVEY

Patient's Name: _____ Phone Number: _____

DISTRESS MANAGEMENT SCALE

Please indicate (0-10) how much **distress** you have experienced over the past week, including today.

❒ 0 ❒ 1 ❒ 2 ❒ 3 ❒ 4 ❒ 5 ❒ 6 ❒ 7 ❒ 8 ❒ 9 ❒ 10

0 = No Distress | 10 = Extreme Distress

Over the past two weeks, how often have you been bothered by any of the following problems?

Yes	No	**Practical Concerns**
❒	❒	Taking care of myself
❒	❒	Taking care of others
❒	❒	Work/School
❒	❒	Housing
❒	❒	Finances or Insurance
❒	❒	Transportation
❒	❒	Child Care
❒	❒	Having enough food
❒	❒	Access to medicine
❒	❒	Treatment decisions

Yes	No	**Social Concerns**
❒	❒	Relationship with children
❒	❒	Ability to have children
❒	❒	Relationship with spouse or partner
❒	❒	Relationship with other family members
❒	❒	Relationship with friends or co-workers
❒	❒	Communication with health care team

Yes	No	**Spiritual Concerns**
❒	❒	Sense of meaning or purpose
❒	❒	Changes in faith or beliefs

Yes	No	**Physical Concerns**
❒	❒	Pain
❒	❒	Sleep
❒	❒	Fatigue
❒	❒	Tobacco use
❒	❒	Substance abuse
❒	❒	Memory or concentration
❒	❒	Sexual health
❒	❒	Changes in eating
❒	❒	Loss or chance in physical abilities

Yes	No	**Emotional Concerns**
❒	❒	Worry or anxiety
❒	❒	Sadness or depression
❒	❒	Loss of interest or enjoyment
❒	❒	Grief or loss
❒	❒	Fear
❒	❒	Loneliness
❒	❒	Anger
❒	❒	Changes in appearance
❒	❒	Feelings of worthlessness or being a burden

Is there anything else we should know? _____

_____

_____

_____