

# London Holistic Needs Assessment

For each item below, please select **yes** or **no** if they have been a concern for you during the last week, including today. Please also select **discuss** if you wish to speak about it with your health professional.

Choose not to complete the assessment today by selecting this box

Date:		<b>Practical concerns</b>	<b>Yes</b>	<b>No</b>	<b>Discuss</b>	<b>Physical concerns</b>	<b>Yes</b>	<b>No</b>	<b>Discuss</b>
Name:		Bathing or dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Breathlessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hospital/NHS number:		Caring responsibilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Changes in taste	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Please <b>select the number</b> that best describes the overall level of distress you have been feeling during the last week, including today:		Difficulty making plans	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Changes in weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	<input type="checkbox"/>	Grocery shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Communication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	<input type="checkbox"/>	Housing or finances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation or diarrhoea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	<input type="checkbox"/>	Information needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	<input type="checkbox"/>	Laundry/housework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry, itchy or sore skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	<input type="checkbox"/>	Preparing food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eating or appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	<input type="checkbox"/>	Transport or parking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	<input type="checkbox"/>	Work or education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feeling swollen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	<input type="checkbox"/>	<b>Family concerns</b>				High temperature	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	<input type="checkbox"/>	Relationship with children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hot flushes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1	<input type="checkbox"/>	Relationship with partner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0	<input type="checkbox"/>	Relationship with others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Moving around/walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<b>Emotional concerns</b>				Nausea and/or vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Anger, frustration or guilt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other medical condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Hopelessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Loneliness or isolation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Passing urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Memory or concentration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Personal appearance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Sadness or depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Sexual concerns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sore or dry mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Worry, anxiety or fear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tingling in hands or feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<b>Spiritual concerns</b>				Wound care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Loss of faith or other spiritual concern	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
		Loss of meaning or purpose in life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
		Regret about the past	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
<b>For health professional use</b>									
Date of diagnosis:									
Diagnosis:									
Pathway point:									

# Care Plan

During my holistic needs assessment, these issues were identified and discussed:

**Preferred name:**

**Hospital/NHS number:**

Number	Issue	Summary of discussion	Actions required/by (name and date)
Example	Breathlessness	Possible causes identified Coping strategies discussed Printed information provided	Referral to anxiety management programme; CNS to complete by 24 <sup>th</sup> Dec
1			
2			
3			
4			

Other actions/outcomes e.g. additional information given, health promotion, smoking cessation, 'My actions':

<b>Patient name:</b>	Signature:	Date:
<b>Healthcare professional name:</b>	Signature:	Date:

For health professional use		
Date of diagnosis:	Diagnosis:	Pathway point: