**Pre-visit Screening Short form**

**Date of visit: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**1. Please review the symptoms below and identity how bothersome each one is to you:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Not at all** | **Somewhat** | **Quite a Bit** | **A Great Deal** |
| Appetite/Weight loss |  |  |  |  |
| Confusion |  |  |  |  |
| Constipation |  |  |  |  |
| Depression/Anxiety |  |  |  |  |
| Hallucinations/delusions |  |  |  |  |
| **Pain**  |  |  |  |  |
| Swallowing difficulty  |  |  |  |  |
| Tiredness/Drowsiness |  |  |  |  |
| Urination |  |  |  |  |
| OTHER: |  |  |  |  |
|  |  |  |  |  |
| Do you struggle with the loss of **meaning** and **joy** in your life? |  |  |  |  |
| Do you currently have what you would describe as **religious or spiritual struggles**? |  |  |  |  |

**2. Please review the questions below and respond by checking Yes or No:**

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| 1. Do you have an **advance directive** (living will, POLST/MOLST/MOST)? |  |  |
| 2. Do you have a **healthcare proxy/Medical Durable Power of Attorney**? |  |  |
| 3. Do you feel that you or **your family** would benefit from additional support? |  |  |