London Holistic Needs Assessment

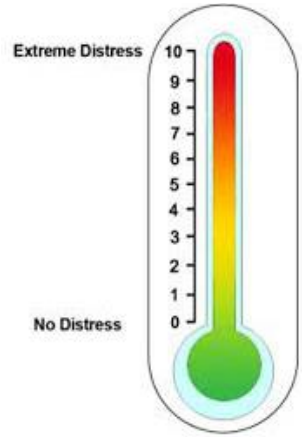
For each item below, please select **yes** or **no** if they have been a concern for you during the last week, including today. Please also select **discuss** if you wish to speak about it with your health professional.

Choose not to complete the assessment today by selecting this box ☐

Date:	
Name:	
Hospital/NHS number:	

Please **select the number** that best describes the overall level of distress you have been feeling during the last week, including today:

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



For health professional use

Date of diagnosis:	
Diagnosis:	
Pathway point:	

Practical concerns	**Yes**	**No**	**Discuss**
Bathing or dressing	☐	☐	☐
Caring responsibilities	☐	☐	☐
Difficulty making plans	☐	☐	☐
Grocery shopping	☐	☐	☐
Housing or finances	☐	☐	☐
Information needs	☐	☐	☐
Laundry/housework	☐	☐	☐
Preparing food	☐	☐	☐
Transport or parking	☐	☐	☐
Work or education	☐	☐	☐
Family concerns			
Relationship with children	☐	☐	☐
Relationship with partner	☐	☐	☐
Relationship with others	☐	☐	☐
Emotional concerns			
Anger, frustration or guilt	☐	☐	☐
Hopelessness	☐	☐	☐
Loneliness or isolation	☐	☐	☐
Memory or concentration	☐	☐	☐
Sadness or depression	☐	☐	☐
Sexual concerns	☐	☐	☐
Worry, anxiety or fear	☐	☐	☐
Spiritual concerns			
Loss of faith or other spiritual concern	☐	☐	☐
Loss of meaning or purpose in life	☐	☐	☐
Regret about the past	☐	☐	☐

Physical concerns	**Yes**	**No**	**Discuss**
Breathlessness	☐	☐	☐
Changes in taste	☐	☐	☐
Changes in weight	☐	☐	☐
Communication	☐	☐	☐
Constipation or diarrhoea	☐	☐	☐
Cough	☐	☐	☐
Dry, itchy or sore skin	☐	☐	☐
Eating or appetite	☐	☐	☐
Fatigue	☐	☐	☐
Feeling swollen	☐	☐	☐
High temperature	☐	☐	☐
Hot flushes	☐	☐	☐
Indigestion	☐	☐	☐
Moving around/walking	☐	☐	☐
Nausea and/or vomiting	☐	☐	☐
Other medical condition	☐	☐	☐
Pain	☐	☐	☐
Passing urine	☐	☐	☐
Personal appearance	☐	☐	☐
Sleep problems	☐	☐	☐
Sore or dry mouth	☐	☐	☐
Tingling in hands or feet	☐	☐	☐
Wound care	☐	☐	☐

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 24th Dec
1			
2			
3			
4			

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

Patient name:	Signature:	Date:
Healthcare professional name:	Signature:	Date:

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