



London Holistic Needs Assessment

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

Choose not to complete the assessment today by ticking this box \square

Date:		Practical concerns	Yes	No	Discuss	Physical concerns	Yes	No	Discuss
		Caring responsibilities				High temperature			
Name:		Housing or finances				Wound care			
		Transport or parking				Passing urine			
Hospital/NHS		Work or education				Constipation or diarrhoea			
number:		Information needs				Indigestion			
Please tick the number that best describes the		Difficulty making plans				Nausea and/or vomiting			
overall level of distress you have been feeling		Grocery shopping				Cough			
during the last week, including today:		Preparing food				Changes in weight			
		Bathing or dressing				Eating or appetite			
10 Extreme di	istress /107 🚹 \	Laundry or housework				Changes in taste			
9 🗆	9 -	Family concerns				Sore or dry mouth			
8 🗆	° 7	Relationship with children				Feeling swollen			
7 🗆	6 -	Relationship with partner				Breathlessness			
6 🗆	5 -	Relationship with others				Pain			
5 🗆	4 -	Emotional concerns				Dry, itchy or sore skin			
4 🗆	3 - 2 - 1	Loneliness or isolation				Tingling in hands or feet			
3 🗆	1-	Sadness or depression				Hot flushes			
2 🗆	0 7	Worry, fear or anxiety				Moving around or walking			
1 🗆		Anger, frustration or guilt				Fatigue			
0 No distress	s	Memory or concentration				Sleep problems			
		Hopelessness				Communication			
		Sexual concerns				Personal appearance			
						Other medical condition			
For health professional us	se	Spiritual concerns							
Date of diagnosis:		Regret about the past							
Diagnosis:		Loss of faith or other spiritual							
		concern							
Pathway point:		Loss of meaning or purpose in life							

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Number

Signed (patient):

For health professional use Date of diagnosis:

Signed (healthcare professional):

Issue Example Breathlessness

Care Plan

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

Actions required/by (name and date)

Date:

Date:

Pathway point:

Hospital/NHS number: Preferred name:

Summary of discussion

Diagnosis:

Example	Breathlessness	Possible causes identified Coping strategies discussed Printed information provided	Referral to anxiety management programme; CNS to complete by 24 th Dec
1		Frinted information provided	
2			
3			
4			
Other act	ions/outcomes e.g. additional informatio	n given, health promotion, smoking cessation, 'My actions':	