

UNDERSTANDING YOUR SYMPTOMS







Edmonton Symptom Assessment System (ESAS-r)

Patient Name (last) _____
 (first) _____
 DOB (dd/mm/yyyy) _____
 PHN _____ MRN _____
 Account / Visit # _____
IH USE ONLY

Completed by (check one): ☐ Patient ☐ Family Caregiver ☐ Health Care Professional ☐ Caregiver-assisted ☐ Unable to assess

What matters to you, matters to us. Your care team would like to understand how your symptoms or distress are affecting your daily life, and how the plan of care is working for you.

It may also help you and your family in discussions with your health care team.

Circle the numbers that best describe how you feel		
     		
1. No Pain	0 1 2 3 4 5 6 7 8 9 10	Worst Possible Pain
2. Not Tired (Tiredness = lack of energy)	0 1 2 3 4 5 6 7 8 9 10	Very Tired
3. Not Drowsy (Drowsiness = feeling sleepy)	0 1 2 3 4 5 6 7 8 9 10	Very Drowsy
4. No nausea	0 1 2 3 4 5 6 7 8 9 10	Worst possible nausea
5. Good appetite	0 1 2 3 4 5 6 7 8 9 10	No appetite
6. No shortness of breath	0 1 2 3 4 5 6 7 8 9 10	Very short of breath
7. No depression (Depression = feeling sad)	0 1 2 3 4 5 6 7 8 9 10	Very depressed
8. Not anxious (Anxious = feeling nervous)	0 1 2 3 4 5 6 7 8 9 10	Very anxious
9. Best wellbeing (Wellbeing = how you feel overall)	0 1 2 3 4 5 6 7 8 9 10	Worst possible wellbeing
10. No _____ Other Problem (e.g. constipation)	0 1 2 3 4 5 6 7 8 9 10	Worst possible
11. No _____ Other Problem (e.g. itching)	0 1 2 3 4 5 6 7 8 9 10	Worst possible
All things considered, how would you rate your Overall Quality of Life? Best Possible	0 1 2 3 4 5 6 7 8 9 10	Worst Possible

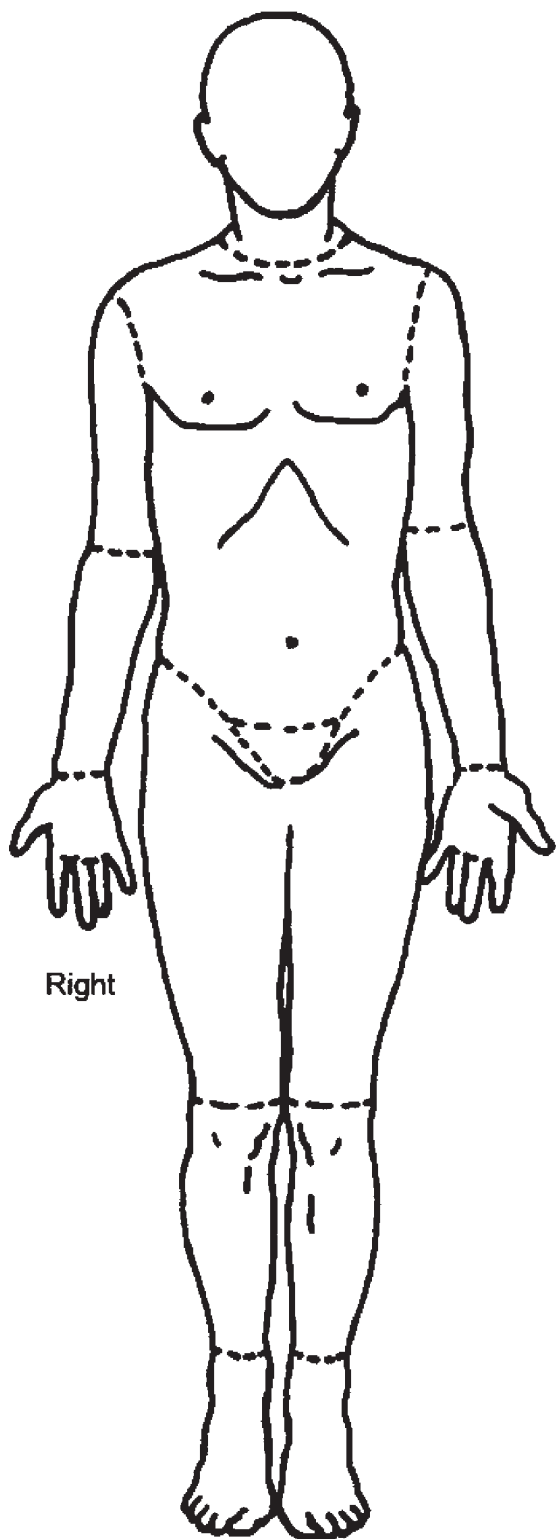
Adapted with permission: Covenant Health, Alberta

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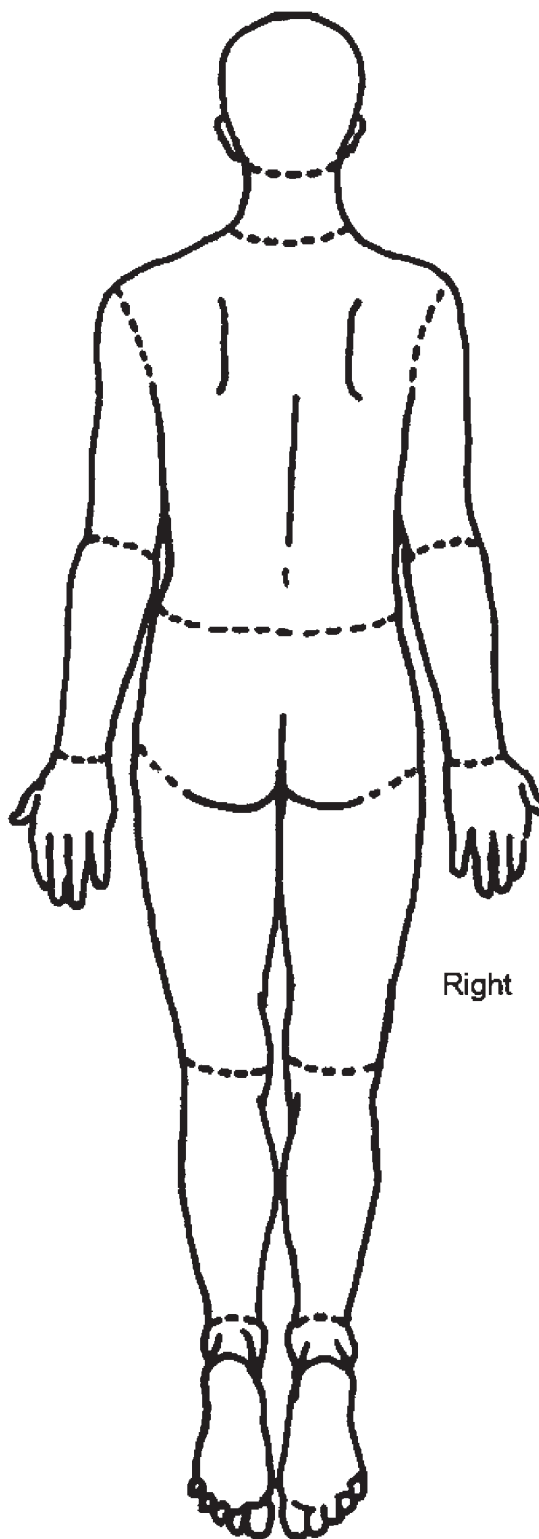
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Please mark on these pictures where it is that you hurt



Right



Right