

# Letting us know your concerns



Name: .....

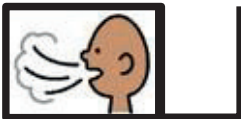


Date: .....



Tick if you have had the concern **in the past week** and would like to speak to a healthcare professional about it.

## 1. Concerns about your body ...



Breathing problems



Problems weeing



Hard to poo



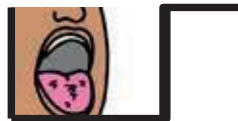
Diarrhoea



Eating /appetite



Indigestion



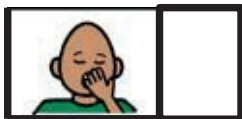
Sore/dry mouth



Feeling/being sick



Sleep problems



Tiredness



Swollen tummy/arm/leg



High temperature



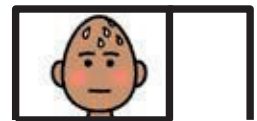
Walking/getting about



Tingling hands/feet



Pain



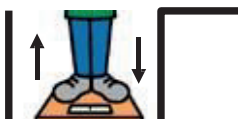
Hot flushes/sweaty



Dry, itchy or sore skin



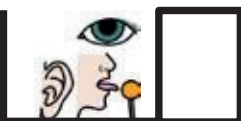
Wound care



Weight changes



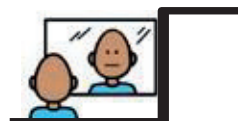
Memory or concentration



Taste/Eyes/Hearing



Speech problems



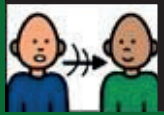
What I look like



My sex life



I have some questions about my diagnosis or treatment.



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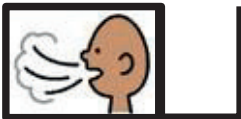


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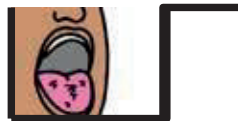
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Eating /appetite



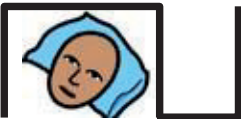
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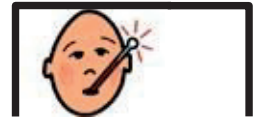
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Tiredness



Swollen tummy/arm/leg



High temperature



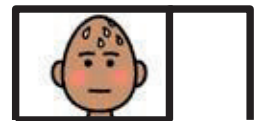
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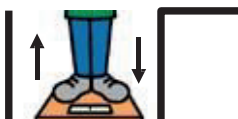
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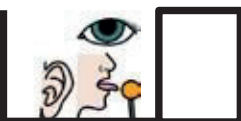
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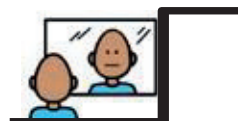
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What I look like




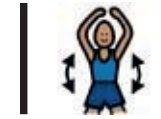



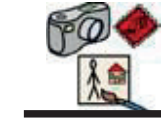





My sex life




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## 6. Other concerns and needs ...

			
Support groups.	Other therapies.	Eating.	Exercise and activity.
			
Smoking.	Alcohol or drugs.	Sun protection.	Hobbies.
			
Stay in work / college.	Making a will.	Other.	

## 7. How do you feel right now?

0 1 2 3 4 5 6 7 8 9 10



					
0	1-3	4-6	7-9	10	
					

Produced by The Learning Disability Service: Lynne Taylor, Strategic Health Facilitator TEWV & Victoria Stenhouse, SLA Speech and Language Therapy HDFT. Eastfield Clinic, Scarborough.