

Concerns and Help Identifier for Medical Patients (CHIMP_cardiology) © Alex J Mitchell 2016

Please let us know if you are struggling with any of the following concerns and if you need help. Please answer as honestly as possible. Your answers will only be used to find appropriate help.

		Do have this concern/problem?			What help do you want for the concern (if any)?			
		NO <i>I don't have this or its already resolved</i>	YES <i>Yes, I have this unresolved issue</i>		Not Now <i>I prefer to deal with this myself right now</i>	Info <i>I need information (online or in print)</i>	Clinician <i>I would like help from a clinician about this</i>	Other <i>I want some other type of help or wish to clarify my concern (write here)</i>
<i>(optional) Patient information</i>								
Medical	Knowing more about my condition	<input type="checkbox"/>	<input type="checkbox"/>	=>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Treatment options or side-effects	<input type="checkbox"/>	<input type="checkbox"/>	=>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Issues with my medical care or staff	<input type="checkbox"/>	<input type="checkbox"/>	=>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Physical Concerns	Fatigue or short of breath	<input type="checkbox"/>	<input type="checkbox"/>	=>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Pain, angina or discomfort	<input type="checkbox"/>	<input type="checkbox"/>	=>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Blackouts, faints, dizzy or falls	<input type="checkbox"/>	<input type="checkbox"/>	=>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Palpitations or heart racing	<input type="checkbox"/>	<input type="checkbox"/>	=>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Pain or swelling in legs	<input type="checkbox"/>	<input type="checkbox"/>	=>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Cough or wheeze	<input type="checkbox"/>	<input type="checkbox"/>	=>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Personal Concerns	Issues with appearance	<input type="checkbox"/>	<input type="checkbox"/>	=>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Loss of independence or dignity	<input type="checkbox"/>	<input type="checkbox"/>	=>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Loss of role (eg at home or at work)	<input type="checkbox"/>	<input type="checkbox"/>	=>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Problems with sleep	<input type="checkbox"/>	<input type="checkbox"/>	=>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Intimacy or relationship Issues	<input type="checkbox"/>	<input type="checkbox"/>	=>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Emotional Concerns	Anger, frustration or irritability	<input type="checkbox"/>	<input type="checkbox"/>	=>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Nervousness or panic	<input type="checkbox"/>	<input type="checkbox"/>	=>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Depression or low motivation	<input type="checkbox"/>	<input type="checkbox"/>	=>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Memory or concentration problems	<input type="checkbox"/>	<input type="checkbox"/>	=>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Low confidence or self-worth	<input type="checkbox"/>	<input type="checkbox"/>	=>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Feel life is not worth living	<input type="checkbox"/>	<input type="checkbox"/>	=>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Practical issues	Issues with family, partner, children	<input type="checkbox"/>	<input type="checkbox"/>	=>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Issues with housing or finances	<input type="checkbox"/>	<input type="checkbox"/>	=>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Issues with finances or bills	<input type="checkbox"/>	<input type="checkbox"/>	=>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Problems getting around (mobility)	<input type="checkbox"/>	<input type="checkbox"/>	=>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other concerns	Worried about the future	<input type="checkbox"/>	<input type="checkbox"/>	=>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Concerned for someone else	<input type="checkbox"/>	<input type="checkbox"/>	=>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Difficulty coping or feel alone	<input type="checkbox"/>	<input type="checkbox"/>	=>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Lifestyle (diet, smoking, alcohol)	<input type="checkbox"/>	<input type="checkbox"/>	=>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Other (please tell us) _____	<input type="checkbox"/>	<input type="checkbox"/>	=>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	