ID: _____
DATE: _____

CTXD

Below are thoughts many people have during or after treatment. Some of the events below may distress or worry you, even if they have not happened.
For each statement, please circle how much **distress or worry** (such as feeling upset, tense, sad, frustrated) it caused you **in the PAST WEEK.**

WHETHER OR NOT THE EVENT HAS OCCURRED, rate how much **DISTRESS** or **WORRY** it caused you in the **PAST WEEK**:

		None	Mild	Moderate	Severe
1.	Medical problems.	0	1	2	3
2.	Not being able to do my usual activities.	0	1	2	3
3.	Long term effects of treatment.	0	1	2	3
4.	Dealing with the medical system.	0	1	2	3
5.	Wondering about the emotional toll on my family or other caregivers.	0	1	2	3
6.	Changes in my appearance.	0	1	2	3
7.	Dealing with insurance.	0	1	2	3
8.	Not knowing what the future will bring.	0	1	2	3
9.	Changes in my body.	0	1	2	3
10.	Getting information when I need it.	0	1	2	3
11.	Not having the same responsibilities in the family.	0	1	2	3
12.	Thinking about possible things that could go wrong.	0	1	2	3
13.	Changes in my sex life because of treatment.	0	1	2	3
14.	Feeling tired or worn out.	0	1	2	3
15.	The family having to help out more than in the past.	0	1	2	3
16.	My hair thinning or falling out.	0	1	2	3
17.	Wondering how to support myself and the family financially.	0	1	2	3
18.	Losing “myself” in all the changes.	0	1	2	3
19.	Thinking about the possibility of relapse.	0	1	2	3
20.	Communicating with medical people.	0	1	2	3
21.	Returning to work.	0	1	2	3
22.	Not being with friends in the same way.	0	1	2	3
23.	Being a burden to other people.	0	1	2	3

ID: _____
DATE: _____

WHETHER OR NOT THE EVENT HAS OCCURRED, rate how much **DISTRESS** or **WORRY** it caused you in the **PAST WEEK**:

		None	Mild	Moderate	Severe
24.	Thoughts about the possibility of dying.	0	1	2	3
25.	The cost of my health care.	0	1	2	3
26.	Not feeling as masculine or feminine as I used to feel.	0	1	2	3
27.	Pain related to my treatment or disease.	0	1	2	3
28.	Not having my usual energy.	0	1	2	3
29.	Physical symptoms such as fatigue, weight loss or weight gain, shortness of breath, sleepiness, constipation or diarrhea, dry mouth, or difficulty remembering.	0	1	2	3

Please list and rate other events that have been distressing to you, if any.

Rate how much **DISTRESS** or **WORRY** it caused you in the **PAST WEEK**:

	None	Mild	Moderate	Severe
30._____	0	1	2	3
31._____	0	1	2	3

32. List the numbers of the 2 Events above (1 through 28 above) that produce the most distress for you in order of their importance:

1. _____ 2. _____

In the PAST WEEK, how much did your DISTRESS or **WORRY INTERFERE with:**

		Interferred **Not at all**	Interferred **A Little**	Interferred **Moderately**	Interferred **A Lot**
33.	General activities.	0	1	2	3
34.	Work.	0	1	2	3
35.	Sleep.	0	1	2	3
36.	Enjoyment of life.	0	1	2	3
37.	Relations with other people.	0	1	2	3

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