**Self-Assessment Questionnaire for Counseling Services**

The following questions may help you determine whether professional counseling would be helpful to you. Circle the answer that best fits for you. There are no right or wrong answers only discovery to determine your needs. If you find that many of your answers are 4’s or 5’s, you may need to talk to a counselor.

**During the past month:**

I have felt anxious or worried about cancer and the treatment I am receiving.

**Not at all 1 2 3 4 5 All the time**

I have felt depressed or discouraged.

**Not at all 1 2 3 4 5 All the time**

I have been irritable or angry and I have not controlled it well.

**Not at all 1 2 3 4 5 All the time**

My sleeping habits have changed.

 **Not at all 1 2 3 4 5 All the time**

I have noticed a change in my appetite.

**Not at all 1 2 3 4 5 All the time**

I have had trouble focusing at work, at home, or on routine things such as everyday tasks.

 **Not at all 1 2 3 4 5 All the time**

Cancer and its treatment have interfered with my family or social life.

**Not at all 1 2 3 4 5 All the time**

Cancer and its treatment have interfered with my sex life.

**Not at all 1 2 3 4 5 All the time**

Pain and discomfort have caused me to limit my activities.

**Not at all 1 2 3 4 5 All the time**

I have had trouble coping with stress.

**Not at all 1 2 3 4 5 All the time**

Cancer and treatment have caused changes in how I look which effect my self-esteem.

**Not at all 1 2 3 4 5 All the time**