CARES-SF
CAncer Rehabilitation Evaluation System
Short Form

Developed
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Patient Information

Name: _____

Date: _____

Age: _____

Sex: M F

Type of Cancer: _____

Date of Diagnosis: _____

Instructions

Below is a list of Problem Statements that describe situations and experiences of individuals who have or have had cancer. Read each statement and circle the number that best describes **HOW MUCH EACH STATEMENT APPLIES TO YOU** during the **PAST MONTH, INCLUDING TODAY.** Some sections will not apply to you. Please skip these sections and proceed to the next one as directed. For any problem statement that you rate between 1 and 4, indicate whether this is a problem with which you would like help by circling *Y* for *yes* or *N* for *no.*

Example

How much does it apply to you?	Not at all	A little	A fair amount	Much	Very much	**Do you want help?**
1. I have difficulty walking	0	(1)	2	3	4	Y (N)
2. I find that food tastes bad	0	1	2	3	(4)	(Y) N

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How much does it apply to you?	Not at all	A little	A fair amount	Much	Very much	Do you want help?
1. I have difficulty bending or lifting	0	1	2	3	4	Y N
2. I do not have the energy I used to	0	1	2	3	4	Y N
3. I have difficulty doing household chores	0	1	2	3	4	Y N
4. I have difficulty bathing, brushing my teeth, or grooming myself	0	1	2	3	4	Y N
5. I have difficulty planning activities because of the cancer or its treatments	0	1	2	3	4	Y N
6. I cannot gain weight	0	1	2	3	4	Y N
7. I find food unappealing	0	1	2	3	4	Y N
8. I find that cancer or its treatments interfere with my ability to work	0	1	2	3	4	Y N
9. I frequently have pain	0	1	2	3	4	Y N
10. I find that my clothes do not fit	0	1	2	3	4	Y N
11. I find that doctors don't explain what they are doing to me	0	1	2	3	4	Y N
12. I have difficulty asking doctors questions	0	1	2	3	4	Y N
13. I have difficulty understanding what the doctors tell me about the cancer or its treatments	0	1	2	3	4	Y N
14. I would like to have more control over what the doctors do to me	0	1	2	3	4	Y N
15. I am uncomfortable with the changes in my body	0	1	2	3	4	Y N
16. I frequently feel anxious	0	1	2	3	4	Y N
17. I have difficulty sleeping	0	1	2	3	4	Y N
18. I have difficulty concentrating	0	1	2	3	4	Y N
19. I have difficulty asking friends or relatives to do things for me	0	1	2	3	4	Y N
20. I have difficulty telling my friends or relatives about the cancer	0	1	2	3	4	Y N

How much does it apply to you?	Not at all	A little	A fair amount	Much	Very much	Do you want help?
21. I find that my friends or relatives tell me I'm looking well when I'm not	0	1	2	3	4	Y N
22. I find that my friends or relatives do not visit often enough	0	1	2	3	4	Y N
23. I find that friends or relatives have difficulty talking with me about my illness	0	1	2	3	4	Y N
24. I become nervous when I am waiting to see the doctor	0	1	2	3	4	Y N
25. I become nervous when I get my blood drawn	0	1	2	3	4	Y N
26. I worry about whether the cancer is progressing	0	1	2	3	4	Y N
27. I worry about not being able to care for myself	0	1	2	3	4	Y N
28. I do not feel sexually attractive	0	1	2	3	4	Y N
29. I am not interested in having sex	0	1	2	3	4	Y N
30. I sometimes don't follow my doctor's instructions	0	1	2	3	4	Y N
31. I have financial problems	0	1	2	3	4	Y N
32. I have insurance problems	0	1	2	3	4	Y N
33. I have difficulty with transportation to and from my medical appointments and/or other places	0	1	2	3	4	Y N
34. I am gaining too much weight	0	1	2	3	4	Y N
35. I have frequent episodes of diarrhea	0	1	2	3	4	Y N
36. I have times when I do not have control of my bladder	0	1	2	3	4	Y N

Do you have children?	Yes	No
If No, skip to next section.		
37. I have difficulty helping my children cope with my illness	0 1 2 3 4	Y N

How much does it apply to you?	Not at all	A little	A fair amount	Much	Very much	Do you want help?
Are you working or have you been been employed during the last month? Yes No *If No, skip to next section.*						
38. I have difficulty talking to the people who work with me about the cancer	0	1	2	3	4	Y N
39. I have difficulty asking for time off from work for medical treatments	0	1	2	3	4	Y N
40. I am worried about being fired	0	1	2	3	4	Y N
Did you look for work during the past month? Yes No *If No, skip to next section.*						
41. I have difficulty finding a new job since I have had cancer	0	1	2	3	4	Y N
Have you attempted sexual intercourse since your cancer diagnosis? Yes No *If No, skip to next section.*						
42. I find that the frequency of sexual intercourse has decreased	0	1	2	3	4	Y N
Are you married or in a significant relationship? Yes No *If No, skip to next section.*						
43. My partner and I have difficulty talking about our feelings	0	1	2	3	4	Y N
44. My partner and I have difficulty talking about wills and financial arrangements	0	1	2	3	4	Y N
45. I do not feel like embracing, kissing, or caressing my partner	0	1	2	3	4	Y N
46. My partner and I are not getting along as well as we usually do	0	1	2	3	4	Y N
47. My partner spends too much time taking care of me	0	1	2	3	4	Y N

How much does it apply to you?	Not at all	A little	A fair amount	Much	Very much	Do you want help?
48. I have difficulty asking my partner to take care of me	0	1	2	3	4	Y N
Are you single and not in a significant relationship? Yes No *If No, skip to next section.*						
49. I have difficulty initiating contact with potential dates	0	1	2	3	4	Y N
50. I have difficulty telling a date about the cancer or its treatments	0	1	2	3	4	Y N
Have you had chemotherapy treatments in the last month? Yes No *If No, skip to next section.*						
51. I become nervous when I get chemotherapy	0	1	2	3	4	Y N
52. I become nauseated during and/or before chemotherapy	0	1	2	3	4	Y N
53. I feel nauseated after I receive chemotherapy	0	1	2	3	4	Y N
54. I vomit after chemotherapy	0	1	2	3	4	Y N
55. I have other side effects after chemotherapy	0	1	2	3	4	Y N
Have you had radiation therapy treatments in the last month? Yes No *If No, skip to next section.*						
56. I get nervous when I get radiation treatments	0	1	2	3	4	Y N
57. I feel nauseous or vomit after my radiation treatments	0	1	2	3	4	Y N
Do you have an ostomy? Yes No *If No, skip to next section.*						
58. I have problems with ostomy care and maintenance	0	1	2	3	4	Y N

How much does it apply to you?	Not at all	A little	A fair amount	Much	Very much	Do you want help?
Do you have a prosthesis?						Yes No
If No, skip to next section.						
59. I have difficulty with my prosthetic device (artificial limb, breast prosthesis, etc.)	0	1	2	3	4	Y N

Please list any additional cancer or treatment–related problems that may not have been addressed:

A. _____

B. _____

C. _____

D. _____

E. _____