Interior Health

SYMPTOM ASSESSMENT ACRONYM O – V

Name _____ DOB _____ PHN _____

Symptom of concern _____

Patient's primary concern
in relation to the symptom _____

Onset	When did it begin? _____ How long does it last? _____ How often does it occur? _____
Provoking / Palliating	What brings it on? _____ What makes it better? _____ What makes it worse? _____
Quality	What does it feel like? Can you describe it?
Region / Radiation	Where is it? _____ Does it spread anywhere? _____
Severity	What is the intensity of this symptom *(On a scale of 0 to 10 with 0 being none and 10 being worst possible)*? _____ Right now? _____ At best? _____ At worst? _____ On average? _____ How bothered are you by this symptom? _____ Are there any other symptom(s) that accompany this symptom? _____
Treatment	What medications and treatments are you currently using for this symptom? How effective are these? _____ Do you have any side effects from the medications and treatments? _____ What medications and treatments have you used in the past?
Understanding / Impact on You	What do you believe is causing this symptom? _____ How is this symptom affecting you and / or your family? _____
Values	What is your goal for this symptom? What is your comfort goal or acceptable level for this symptom *(0 = none, 10 = worst possible)*? _____ Are there any other views or feelings about this symptom that are important to you or your family?

Physical assessment *(as appropriate for symptom)*

Date _____ Signature _____

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