# Edmonton Symptom Assessment System: (revised version) (ESAS-R)

Please circle the number that best describes how you feel NOW:

<table>
<thead>
<tr>
<th>Symptom</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Pain</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Worst Possible Pain</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No Tiredness</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>7</td>
<td>8</td>
<td>9 10</td>
</tr>
<tr>
<td>Tiredness (lack of energy)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Worst Possible Tiredness</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No Drowsiness</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>7</td>
<td>8</td>
<td>9 10</td>
<td></td>
</tr>
<tr>
<td>Drowsiness (feeling sleepy)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Worst Possible Drowsiness</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No Nausea</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>7</td>
<td>8</td>
<td>9 10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Worst Possible Nausea</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No Lack of Appetite</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>7</td>
<td>8</td>
<td>9 10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Worst Possible Lack of Appetite</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No Shortness of Breath</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>7</td>
<td>8</td>
<td>9 10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Worst Possible Shortness of Breath</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No Depression</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>7</td>
<td>8</td>
<td>9 10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression (feeling sad)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Worst Possible Depression</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No Anxiety</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>7</td>
<td>8</td>
<td>9 10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety (feeling nervous)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Worst Possible Anxiety</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Best Wellbeing</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>7</td>
<td>8</td>
<td>9 10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wellbeing (how you feel overall)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Worst Possible Wellbeing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No Other Problem (for example constipation)</td>
<td>0</td>
<td></td>
<td></td>
<td>7</td>
<td>8</td>
<td>9 10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Patient’s Name __________________________________________

Date _____________________ Time ______________________

Completed by (check one):
- ☐ Patient
- ☐ Family caregiver
- ☐ Health care professional caregiver
- ☐ Caregiver-assisted

BODY DIAGRAM ON REVERSE SIDE
Please mark on these pictures where it is that you hurt: