Spiritual Care Screening Tool

For Patient to complete

Patient Name: _____ **DOB**: _____ **Date**: _____

1. **Do you have any spiritual needs where we can offer support?** *(Please check one.)*

☐ Yes ☐ No

2. **How urgent is that need?** *(Please circle one.)*

Extremely urgent. I am desperate!!

I need help urgently.

I need help, but it is not urgent.

I am ok.

3. **How would you describe your faith today?** *(Please circle one.)*





Active Beginning Stage Unsure/Questioning Open/Curious Not Interested

4. **My spiritual practices at this moment are:** *(Please circle all that apply)*

None

Prayer

Devotion

Attending church or faith community

Sacred scripture reading/studying

Other: _____

5. **How close/far do you feel from God at this time in your life? (***Please check one.)*

☐ Very Close ☐ Somewhat Close ☐ Not Sure ☐ Somewhat Far ☐ Very Far

6. **What is your religious preference?** _____

7. **Do you have any religious beliefs that may affect your medical decisions?**

If yes, please explain: _____

_____

8. **Would you like us to pray with you?** ☐ Yes ☐ No

If yes, what is your prayer request? *(This is optional.)*_____

_____

9. **Do you have someone who cares for you and loves you?** *(Please check one.)*

Yes☐ No ☐