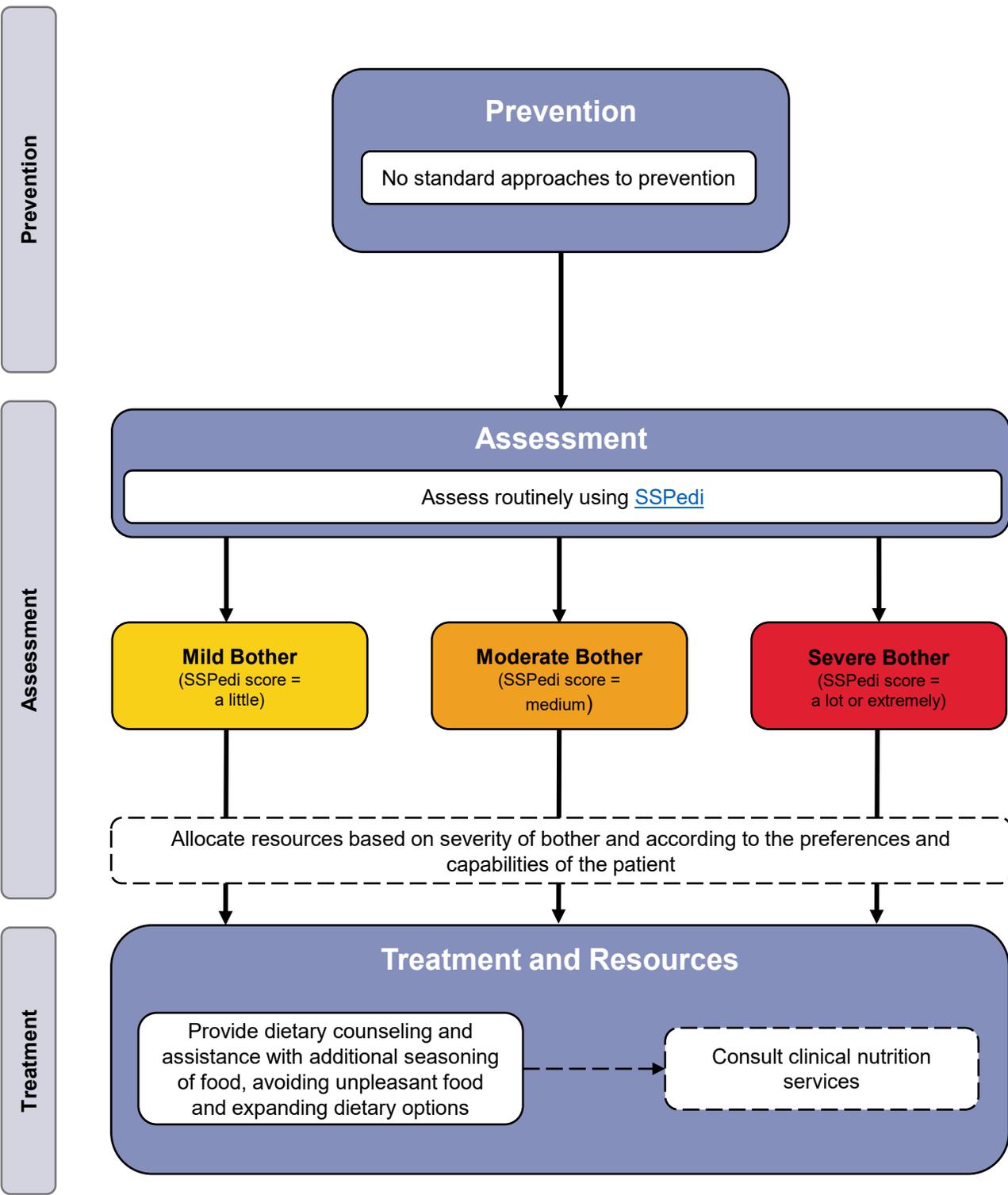


# Taste Alteration Care Pathway



## Care Pathway

### SSPedi: Symptom Screening in Pediatrics



Please tell us how much each of these things **bothered** you **yesterday or today** by ticking the circle that best describes the amount it bothered you:

	Not at all bothered	A little	Medium	A lot	Extremely bothered
Feeling disappointed or sad	<input type="radio"/>				
Feeling scared or worried	<input type="radio"/>				
Feeling cranky or angry	<input type="radio"/>				
Problems with thinking or remembering things	<input type="radio"/>				
Changes in how your body or face look	<input type="radio"/>				
Feeling tired	<input type="radio"/>				
Mouth sores	<input type="radio"/>				
Headache	<input type="radio"/>				
Hurt or pain (other than headache)	<input type="radio"/>				
Tingly or numb hands or feet	<input type="radio"/>				
Throwing up or feeling like you may throw up	<input type="radio"/>				
Feeling more or less hungry than you usually do	<input type="radio"/>				
Changes in taste	<input type="radio"/>				
Constipation (hard to poop)	<input type="radio"/>				
Diarrhea (watery, runny poop)	<input type="radio"/>				

Please tell us about any other things that have bothered you lately by writing about them here.