Alberta Health Services

Getting to Know You

Affix patient label within this box

Comments/Notes

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Please fill out the following and bring a copy with you to share at medical visits with your care providers. You are not obligated to share any information that you are not comfortable sharing.

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr.	First Name
Last Name	Maiden Name

Communication

What do you prefer to be called?

What is your first language?

How is your English?
☐ Fluent (I speak and understand it)
☐ Understand it
☐ I do not speak or understand English

Is the use of touch okay?	Hearing is	Vison is	If you have any aids for either hearing or vision, what are they?
☐ Yes ☐ No	☐ Good ☐ Fair ☐ Weak	☐ Good ☐ Fair ☐ Weak	

History

Where do you live?	Where were you born?
☐ Own Home ☐ Relative's/Friend's Home ☐ Lodge ☐ Supportive Living ☐ Long Term Nursing Home	How far did you go in school (i.e. level of education you attained)?
	What was your favorite job?

What would you like to share about your spiritual beliefs and your cultural/family customs?

Closest Family and Friends ***{Please tell us their names and a little about them (where they live, work, etc.)}***

Partner

Children

Children

Children

Grandchildren

Siblings and Friends

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Likes, Dislikes and Difficulties *(People, pets, foods, sports, music, TV, movies, hobbies, games, etc)*

What 3 things do you enjoy most?

What do you not enjoy?

What are your current and past activities and interests?

List some of your special moments and successes. Who were they shared with?

Do you dislike or have difficulty with any of the following? If so, fill in the blank beside it with at least one thing that helps make you feel better in that situation.

Psychosocial

- ☐ Large Groups _____
- ☐ Agitation _____
- ☐ Small Groups _____
- ☐ Getting Lost _____
- ☐ Noise _____
- ☐ Hallucinations _____
- ☐ Other *(specify)* _____

Physical

- ☐ Using the Toilet _____
- ☐ Falling _____
- ☐ Urinary Leakage _____
- ☐ Sleeping _____
- ☐ Bathing _____

Routine

When do you wake up?	Go to bed?	Do you nap? ☐ Yes ☐ No

How is your appetite?	Can you swallow food easily?	Do you use dentures or adapted cutlery/aids to eat?	Do you sit up to eat?
☐ Good ☐ Fair ☐ Poor	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Do you have a food allergy?

What foods/drinks are your favourite?

What foods do you really dislike?

Please indicate which of the following daily activities you like to do. Leave a comment if you'd like

Walk Outside	☐ Yes	☐ Sometimes	☐ No	_____
Listen to the Radio	☐ Yes	☐ Sometimes	☐ No	_____
Watch TV	☐ Yes	☐ Sometimes	☐ No	_____
Read the Newspaper/Books	☐ Yes	☐ Sometimes	☐ No	_____
Play Games/Do Hobbies	☐ Yes	☐ Sometimes	☐ No	_____

Are there other routines that are important to you? *(Grooming, attending religious institution, etc.)*

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Mobility & Independence

Date *(yyyy/Mon/dd)* _____

Do you need help to walk?	☐ Yes	☐ Sometimes	☐ No
Are you able to do stairs?	☐ Yes	☐ Sometimes	☐ No
Do you use a walking aid?	☐ Yes	☐ Sometimes	☐ No
Are you able to dress yourself?	☐ Yes	☐ Sometimes	☐ No
Are you able to clean/groom yourself?	☐ Yes	☐ Sometimes	☐ No

What kind of assistance do you need with the above?

_____

Do you use a special chair/cushion?	☐ Yes	☐ Sometimes	☐ No
Do you have to raise your feet to relax?	☐ Yes	☐ Sometimes	☐ No
Do you partake in physical activity?	☐ Yes	☐ Sometimes	☐ No

If so, what do you do? _____

Do you have pain/discomfort? ☐ Yes ☐ Sometimes ☐ No

If so, where? _____

Does anything make the pain/discomfort worse? _____

Does anything make the pain/discomfort better? _____

Extra

Do you have help with banking or other financial matters?

☐ No

☐ Yes - If Yes, who helps you? Name _____ Phone _____

Relationship _____

Does anyone have legal authority to help you with decisions?

☐ No

☐ Yes *(check all that apply)*

- ☐ Enduring Power of Attorney: Name _____ Phone _____
- ☐ Substitute Decision Maker: Name _____ Phone _____

In case of emergency, who should we contact?

1. Name _____ Phone _____

   Name _____ Phone _____

Are you aware if you have a Goals of Care Designation? *(a medical order that guides future decision making)*

☐ No

☐ Yes

Completed by *(print name)*	Relationship	
Signature	Date *(yyyy-Mon-dd)*	Time *(hh:mm)*