Alberta Health Services

Last Name *(Legal)*	First Name *(Legal)*	
Preferred Name ☐ Last ☐ First	DOB *(dd-Mon-yyyy)*	
PHN	ULI ☐ Same as PHN	MRN
Administrative Gender ☐ Male ☐ Female ☐ Non-binary/prefer not to disclose (X)		

Getting to Know You

Please fill out the following and bring a copy with you to share at any medical health care related visit. Please share only the information that you are comfortable sharing. The purpose of *"Getting to Know You"* is to provide patient centered care for you. If you receive this form via email, do **not** email a completed form back to sender *(due to the personal and sensitive information contained in it)*. If you cannot bring the completed form back to the health care provider *(or if you have questions about completing the form)* please contact the AHS health care provider that sent the form to you. The AHS provider will review the form with you over the phone and enter the information on the patient's health record on your behalf.

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

Communication

Please call me by this name:			
What is your first language?			
How is your English? ☐ Fluent *(I speak it and understand it)* ☐ I do not speak or understand English			☐ Understand it
Is the use of touch okay? ☐ Yes ☐ No	Hearing is ☐ Good ☐ Fair ☐ Weak	Vison is ☐ Good ☐ Fair ☐ Weak	If you have any aids for either hearing or vision, what are they?

History

Where do you live? ☐ Own Home ☐ Relative's/Friend's Home ☐ Lodge ☐ Supportive Living ☐ Long Term Nursing Home	Where were you born?
	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?
Example: cultural dietary considerations, routine spiritual practices/considerations

Closest Family and Friends *Please tell us their names and a little about them such as where they live, work, etc.). You may use the comment section at the end of the form for more details if needed.*

Name	Relationship	Details

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Getting to Know You

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

Do you have a food allergy?

What foods/drinks are your favorite?

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

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 - 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

Information provided by *(print name)*	Relationship	Date *(dd-Mon-yyyy)*

Staff use only

Information recorded by *(print name)*	☐ In Person ☐ By phone	Date *(dd-Mon-yyyy)*

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Comments/Notes

Alberta Health Services collects health information in accordance with Section 20 of the Health Information Act (HIA) for the purpose of providing health services, determining eligibility for health services, or to carry out any other purpose authorized by the HIA. If you have any questions about this collection, please ask your health care provider or contact the Chief Privacy Officer at 1.877.476.9874.