Alberta Health Services

Getting to Know You

Affix patient label within this box

Comments/Notes

Alberta Health Services

Getting to Know You

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.

Affix patient label within this box

☐ 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? ☐ 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?

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

Sample

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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

Activity				Comment
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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Getting to Know You

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 ____________

What are your Goals of Care Designations? *(as discussed with your Healthcare Providers)*

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

Sample