ASSISTANCE DOG APPLICATION: CLIENT FORM

This form is to be completed by the applicant or at the direction of the applicant.

CLIENT INFORMATION

Name ____

Address ____

Phone (H) __________________ (W) ____________________ (C) _______________________

Email address ____

Date of Birth ____________ **Height** ___________ **Weight** ___________ **Gender** ___________

Primary disability ____ **Date of onset** _________

Cause of disability and how it came about (example - spinal cord injury due to auto accident):

____

____

____

Other disabilities or medical conditions ____

____

Please indicate any special information related to your disability or other medical conditions (hyperreflexia management, seizure precautions, etc) ________________________________

____

____

Medical Emergencies (please check all that apply)

___Required medical assistance (from EMT, hospitalization, etc.) ____ times in the past year due to a medical event related to your disability/medical condition.

___Required help from personal support (parent, spouse, etc.) ____ times in the past year due to a medical event related to your disability/medical condition.

How many hours of attendant care do you receive each week? ________________________

If you have diabetes, please provide your last A1C level ____ and the date it was taken ____

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HOUSEHOLD

With whom do you live? (check all that apply) __ Alone __ With parent(s) _ With attendant

__With spouse/significant other __ With roommates __ Other ________________________

Does anyone in your household smoke? _ Yes __ No

Does anyone in the household besides applicant have diabetes or other major medical conditions? __ Yes ___No

If yes, please explain: ____

Where do you live? ___House ___Apartment ___Dorm Other ________________________

Does it have a ___ Fenced yard ___ Enclosed area outside ___ Neither

Do you live with children or have children regularly visit your home? Yes No

If so, how many and what ages? ____

____

Have you ever owned ___ an assistance dog or ___ a pet dog before?

IMPAIRMENT MEASUREMENT

Please rate the severity of the following impairments and conditions using this scale:

0 = no impairment	***1 = mild***	***2 = moderate***	***3 = severe***

I. Motor impairments

Weakness	0	1	2	3
Coordination	0	1	2	3
Spasticity	0	1	2	3

II. Sensory impairments

Vision	0	1	2	3
Hearing	0	1	2	3
Loss of sensation	0	1	2	3

III. Cognitive impairments

Attention	0	1	2	3
Memory	0	1	2	3
Problem solving	0	1	2	3
Judgment	0	1	2	3

IV. Communication impairments

Comprehension	0	1	2	3
Expression	0	1	2	3

V. Psychological/behavioral descriptions

Depressed	0	1	2	3
Difficulties managing stress	0	1	2	3
Impulsive	0	1	2	3
Inappropriate	0	1	2	3

VI. Additional medical conditions

Cardiovascular disease	0	1	2	3
Respiratory disease	0	1	2	3
Diabetes	0	1	2	3
Seizure disorder	0	1	2	3
Chronic pain	0	1	2	3
Neurogenic bladder	0	1	2	3
Neurogenic bowel	0	1	2	3

Please list other medical conditions:

FUNCTIONAL INDEPENDENCE MEASURE

Please identify your Functional Independence Measure (FIM) levels for the following motor activities using this scale:

NO HELPER
7 = Complete independence (timely, safely)
6 = Modified independence (device)
HELPER – MODIFIED INDEPENDENCE
5 = Supervision
4 = Minimal assistance (you can perform 75% of activity)
3 = Moderate assistance (you can perform 50% of activity)
HELPER – COMPLETE DEPENDENCE
2 = Maximal assistance (you can perform 25% of activity)
1 =Total assistance (you can perform 0% of the activity)

__ I am completely independent in all areas of self-care *(if so, skip to "locomotion")*

Self-Care

Eating	1	2	3	4	5	6	7
Grooming	1	2	3	4	5	6	7
Bathing	1	2	3	4	5	6	7
Dressing-upper body	1	2	3	4	5	6	7
Dressing-lower body	1	2	3	4	5	6	7
Toileting	1	2	3	4	5	6	7

Sphincter Control

Bladder management	1	2	3	4	5	6	7
Bowel management	1	2	3	4	5	6	7

Transfers

Chair, wheelchair	1	2	3	4	5	6	7
Toilet	1	2	3	4	5	6	7
Tub, shower	1	2	3	4	5	6	7

Locomotion

__ I do not use an assistive device for walking *(if so, skip to "current medications")*

__ I use a: *(please put in the % of time used during a typical day)*

Walk without assistive device ____%

Cane ____% Walker ____% Crutches ____%

Manual Wheelchair ____% Power wheelchair / Scooter ____%

Brace____% Prosthesis____%

Other Assistive devices (please list): ____

CURRENT MEDICATIONS

Please list both prescription and over-the-counter medications

Medication	Dose	Frequency	Taken for

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Please briefly describe how you believe a Service Dog will assist you:

How did you hear about Eyes Ears Nose and Paws?

The information on this application is correct to the best of my knowledge.

____

Applicant Signature	*Printed Name*	*Date*

____

Parent/Guardian Signature *(if applicant is under 18)*	*Printed Name*	*Date*

____

Person who completed this form *(if not completed by applicant)*	*Printed Name*	*Relationship*