Assistance Service Dog Educational Center
Applicant Medical History Form

This form is to be completed by your physician and sent together with your other application materials to the Assistance Service Dog Educational Center.

Dr. ________________________________,

Please release the requested information regarding my condition to the above identified organization. This information will help determine my abilities in regards to the placement of an assistance dog.

Applicant's Name (please print): ____________________________________

Applicant's Signature: ____________________________ Date: __________

Doctor's Name: ____

Type of practice: ____

Address ____

City ______________________ **County** ____________ **State** ___________ **Zip** ____________

Phone ___________________________ **Fax** _________________________________

Patient Information:

What is this patient's primary disability? ____________________________________
What was the cause of the disability? ____
Are there significant secondary disabilities?....................................[ ] Yes [ ] No
If so, please describe: ____
At what age was (s)he disabled? __________ **Is this disability progressive?**.... [ ] Yes [ ] No
Is there an incapacity due to or affected by alcoholism or drug abuse.........[ ] Yes [ ] No

Check all that apply:

What are the effects of your disability? (Circle all that apply)

Deafness Speech impairment Reduced Stamina Hearing Loss
Coordination problems Limited mobility Memory loss Spasticity
Slowed development Vision impairment Muscular weakness
Other: ____

Does patient have any problems with...(circle all that apply)

Allergies Chronic pain Heightened emotions Depression Seizures
Skin sensitivity Balance Brittle bones Heat/Cold sensitivity

Does patient use an aid or assistive device? (Circle all that apply)

Prosthesis Leg brace Wheelchair (electric) Wheelchair (manual)
Wrist brace Hearing aid Crutch/cane Walker Other: ____________________