

ADULT CLIENT APPLICATION AND MEDICAL HISTORY

LOVING ANGEL SERVICE DOGS, INC.

PLEASE PRINT CLEARLY **DATE** _____

GENERAL

First Name _____ Last Name _____

Street Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

E-Mail _____

Date of birth (mm/dd/yyyy) _____ Age _____ Gender ☐ M ☐ F

Approximate weight _____ Approximate height _____

Marital status ☐ Single ☐ Married ☐ Divorced ☐ Separated

Employer _____ Work Phone _____

Spouse Name _____

Nearest Relative Name _____ How Related _____

Street Address _____

City _____ State _____ Zip _____

Daytime Phone _____ Cell Phone _____

(Including Area Code)

E-Mail _____

PHYSICIAN INFORMATION

Name _____ Type of practice _____

Phone (Including area code) _____

City _____ State _____ Zip _____

Is your doctor available for a consultation regarding this application? ☐ Yes ☐ No

APPLY FOR SERVICE DOG TRAINING
LOVING ANGEL SERVICE DOGS, INC.
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DISABILITY INFORMATION

What is your primary disability? _____

Please list secondary disabilities, if any _____

What caused your disability or disabilities? _____

If caused by an injury, what progress has been made since the injury? _____

How does it affect your life (limitations)? _____

How long have you been disabled? _____

Is your disability progressive? ☐ Yes ☐ No

Are there any current changes in your disability? ☐ Yes ☐ No

If yes, explain

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

- ☐ Deafness ☐ Speech Impairment ☐ Reduced Stamina ☐ Hearing Loss ☐ Spasticity
☐ Limited Mobility ☐ Muscular Weakness ☐ Slow Development ☐ Vision Impairment
☐ Memory Loss

Explain in more detail *anything* that will better help us to understand your needs.

**APPLY FOR SERVICE DOG TRAINING
LOVING ANGEL SERVICE DOGS, INC.
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DOG INFORMATION

What kind of dog are you looking for?

☐ Public Access Service dog ☐ In-home skilled dog ☐ Facility dog

How do you think your dog will be able to help you? _____

What skills do you hope your dog will have? _____

Do you currently have, or have you ever had a service dog? ☐ No ☐ Current ☐ In the Past

If so, who trained your dog? _____

How many years did the dog partner with you? _____

Having a service dog is an incredible opportunity that can enhance your life in many areas – physically, emotionally, spiritually and socially. Along with those benefits come associated responsibilities. As the owner of a service dog, your team not only represents Loving Angel Service Dogs, but you are also an ambassador and a public educator on behalf of all service dogs. It is vital that you and your dog are well mannered and clean and neat when you are out in public.

Our training program is physically and emotionally demanding. What specific difficulties might you have with it? _____

What modifications do you need to make to accommodate this training? _____

Are you committed to daily training (2-3 15 minute sessions) of your dog?

Signature _____ Date _____

All the information I have provided is true to the best of my knowledge, up-to-date and accurate

**SEND YOUR COMPLETED APPLICATION ALONG WITH A \$40 CHECK MADE OUT TO
LOVING ANGEL SERVICE DOGS, INC.
3734 SUGAR LEO RD.
ST. GEORGE, UT 84790**

ADULT CLIENT APPLICATION AND MEDICAL HISTORY

LOVING ANGEL SERVICE DOGS, INC.

PLEASE PRINT CLEARLY

MEDICAL HISTORY FORM

PUT YOUR NAME ON EACH PAGE and sign the release below and give all four pages to your physician or therapist to complete. Ask them to return it directly to Loving Angel Service Dogs

RELEASE OF MEDICAL INFORMATION

This authorizes you to release information regarding my condition to Loving Angel Service Dogs, Inc. This information will be used to evaluate and assess my situation and is essential for Loving Angel to train a service dog to increase my independence. All information is confidential.

Name _____ Date of Birth _____

Signature

To the Physician or Therapist:

We maintain confidentiality of our clients' records. The information you give here will not be shared with your patient unless you give express permission.

If you have any questions, please contact Loving Angel Service Dogs, Inc. at (435) 632-2482

Mail the completed form to:

Executive Director
Loving Angel Service Dogs, Inc.
3734 Sugar Leo Rd.
St. George, UT 84790

LOVING ANGEL SERVICE DOGS, INC.

MEDICAL HISTORY FORM

PAGE 1

PATIENT NAME _____ DATE _____

PRACTIONER'S NAME: _____ SPECIALTY _____

Address: _____

Phone: _____

Date of Last Exam: _____ Length of association with patient: _____

What is the primary diagnosis? _____

What other conditions does the patient have? _____

How severe is the patient's mobility impairment?

NONE		NEEDS ASSISTIVE DEVICE		NEEDS FULL-TIME CARE
1	2	3	4	5

How severe is the patient's visual impairment?

NONE(correctible w/ glasses		NEEDS ASSISTIVE DEVICE		BLIND
1	2	3	4	5

How severe is the patient's auditory impairment?

NONE		NEEDS ASSISTIVE DEVICE		DEAF
1	2	3	4	5

How severe is the patient's cognitive impairment?

NONE		NEEDS ASSISTIVE DEVICE		NEEDS FULL-TIME CARE
1	2	3	4	5

Do limitations affect patient's ability to control his/her own behavior?

NORMAL		MODERATE		POOR SELF CONTROL
1	2	3	4	5

How effective is the patient on handling and overcoming their limitations?

VERY COMPETENT		MODERATE		INEFFECTIVE
1	2	3	4	5

MEDICAL HISTORY FORM

PATIENT NAME _____

VERY RELIABLE		MODERATE		UNRELIABLE	
1	2	3	4	5	

NORMAL		MODERATE		TOTALLY NEEDS HELP	
1	2	3	4	5	

COGNITIVE AND MENTAL EVALUATION:

	Yes	Minimal	No
Able to exercise judgment and make decisions necessary for ADL	_____	_____	_____
Able to sustain attention span	_____	_____	_____
Manifests inappropriate behavior beyond his/her control	_____	_____	_____
Able to control physical or motor movement sufficient to sustain ADL	_____	_____	_____
Capable of perception and memory to the degree necessary to sustain ADL	_____	_____	_____
Able to follow directions and learn to the degree necessary to Sustain ADL	_____	_____	_____
Under medication which impairs functioning	_____	_____	_____
Capable of decision about personal and others' needs and safety	_____	_____	_____

LOVING ANGEL SERVICE DOGS, INC.

MEDICAL HISTORY FORM

PAGE 3

PATIENT NAME _____

Our service dogs are highly trained to assist their partners with many tasks besides being a loyal companion who gives unconditional love. Some of the tasks they may be trained to do are:

Retrieve dropped articles
Push Lifeline or 911 button
Find help
Retrieve items from refrigerator
Turn lights off and on
Open and close doors
Provide bracing for transfers

Enhance balance when walking
Enhance balance when taking the stairs
Assist in pulling wheelchair
Carry items in mouth or backpack
Take items to another person
Help undressing – shoes, socks, sweaters, etc.
Find and retrieve items like keys, etc.

Are there any other tasks that a service dog could do that your patient would benefit from?

Do you think your patient will be capable of training a service dog (with guidance and help from the Agency)? Yes No How? Or Why not?

May we contact you with questions? Yes No

Best way to contact you _____

Any addition comments: _____

Signature of physician or therapist: _____ Date _____