Healing Paws For Heroes

Medical History Form

Applicant Medical History Form

**This form is to be completed by your physician and sent together with your other**

**application materials to Healing Paws For Heroes.**

Information Release:

Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

Please release the requested medical information regarding my condition to the above

identified organization. This information will be used to 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 is the cause of this disability?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there significant secondary disabilities? ( ) Yes ( ) No

If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this disability progressive? ( ) Yes ( )No

Is there an incapacity due to alcohol or drug abuse? ( ) Yes ( ) No

**PLEASE CIRCLE ALL THAT APPLY:**

***The effects of this patient's disability include***:

*Speech impairment Reduced stamina Hearing loss*

*Coordination problems Limited mobility Memory loss*

 *Muscular weakness*

*Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

***Does this patient have trouble with...***

*Allergies Chronic pain Heightened emotions Depression*

*Seizures Balance*

***Does this patient use any of the following aids or assistive devices?***

*Prosthesis Leg brace Wheelchair- manual Wheelchair- electric*

*Wrist brace Hearing aid Crutch/cane Walker*

*Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*The Dogs we pick for PTSD/Severe Anxiety are VERY sensitive to any mood changes and are trained to intervene and get in between in any heightened emotional situations. In order for the dogs to do their best we like to work with the client's therapist/Doctor so that we can know what to target the dogs towards and make sure that we have a great match. That being said:*

*If this Dog is for PTSD/ Agoraphobia/ Severe anxiety are you willing to meet/speak with a member of our staff to work out a good therapy based training schedule for the client and the dog they are paired with? Yes/ No*

*Doctor Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Doctor Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*