Paws for Freedom

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Medical History Form

This form is to be completed by your primary physician and sent together with your other application materials to Paws for Freedom, Inc.

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 a service or companion dog.

Applicant's Name (please print): _____

Applicant's Signature: _____ Date: _____

Doctor's Name: _____

Type of practice: _____

Address: _____

City: _____ State: _____

Zip: _____ County: _____

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 incapacity due to or affected by alcoholism or drug abuse?
_____Yes _____No

Please circle 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 the 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 the patient use an aid or assistive device? (Circle all that apply)

Prosthesis Leg brace Electric wheelchair Manual wheelchair
Wrist brace Hearing aid(s) Crutch/cane Walker Other:
_____

Current number of hours of attendant care per week: _____

Does the patient… (Circle all that apply)

Drive Ride buses Fly Driven by others
Travel distance on foot/wheels Other: _____

ADL = Activities of Daily Living

Is this patient: Please Circle Below

A. Able to exercise judgment and make decisions necessary for ADL?	Yes	Minimally	No
B. Able to sustain an attention span?	Yes	Minimally	No
C. Manifesting inappropriate behavior beyond his/her control?	Yes	Minimally	No
D. Able to control physical and motor movement sufficient to sustain ADL?	Yes	Minimally	No
E. Capable of perception and memory to the degree necessary to sustain ADL?	Yes	Minimally	No
F. Able to follow directions and learn to the degree necessary to sustain ADL?	Yes	Minimally	No
G. Under medication which impairs physical or mental functioning?	Yes	Minimally	No
H. Capable of decisions concerning self and others' needs and safety?	Yes	Minimally	No

Can you recommend this individual for a service or companion dog? _____Yes _____No

Do you feel Paws for Freedom, Inc. might benefit from a consultation with you?

_____Yes _____No

Comments: _____

_____

_____

Physician Signature:_____ Date:_____

Thank you!