Preliminary Assistance and Service Dog Application

Highland Canine Training, LLC
145 Foxfield Drive
Harmony, NC 28634
www.highlandcanine.com
866.200.2207

Personal Information *(to be completed by parent or guardian if under 18)*

Name _____
Street Address: _____
City_____ State _____ Zip _____
Home phone (___) _____ - _____Cell (____)____ -_____ Other (____)____ -_____
Email Address _____
D.O.B _____
Sex *(circle one)* Male Female Height _____' _____" Weight _____lbs

Parent or Guardian Name _____

School Name _____Public / Private *(circle one)*
Street Address: _____
City_____ State _____ Zip _____
Office phone (___) _____ - _____ County _____ District _____

Doctors Name _____
Office Name *(if applicable)* _____
Street Address: _____
City_____ State _____ Zip _____
Office phone (___) _____ - _____

Primary Diagnosis_____
Age at time of Diagnosis _____
Secondary Diagnosis _____
With whom do you live?_____
How many hours per week are you in school or therapies _____
What types of therapies are you currently involved in (including special programs at school)
_____
_____
_____
_____

Please describe the most significant symptoms of the illness and how it affects you:

_____
_____
_____
_____

(Attach sheet if necessary)

You currently resides in a *(please circle)* house apartment duplex

Other persons in your home:

Name _____ D.O.B _____
Sex *(circle one)* Male Female

Name _____ D.O.B _____
Sex *(circle one)* Male Female

Name _____ D.O.B _____
Sex *(circle one)* Male Female

Name _____ D.O.B _____
Sex *(circle one)* Male Female

Your residence currently has: (please circle) fenced yard enclosed area other

_____

Do you have other pets? (list species, breed, age and sex)

_____
_____
_____

Is anyone in your home allergic to dogs or pet dander?

_____

Have you previously owned a service or assistance dog?

_____

Describe the ways you believe a Service Dog can assist you. What are your hopes, fears, goals?

Do you have any experience working with animals? _____ If yes, please explain.

Will your family accept a trained dog as an equal partner in your house? □ Yes □ No

Where will your dog be taken for toilet requirements?

When do you get out of bed in the morning?

What time do you retire in the evening?

Who will help you with the dog's care if you are sick and cannot get outside:
Name Phone

Proximity to the your home

Where will the dog be exercised and have playtime?

Describe your daily schedule.

Do you have any concerns regarding owning a service dog?

How much exercise, on average, per day, do you think that a dog needs?

Describe your definition of exercise and an exercise plan you could implement for your dog.

Are you willing to participate in on-going training sessions once you receive a Service Dog? □Yes □ No

Check any and all medical problems that apply to you:

□ Arthritis Heart Disease
□ Alcohol or Drug Dependency
□ High Blood pressure
□ Visual Impairment
□ Diabetes
□ Asthma Seizures or fainting
□ Psychiatric Problems
□ Hearing impairment
□ Allergies (list)
Other_____

Do you use a wheelchair? □ Yes □ No If so, electric or manual?

Do you use any other mobility aides? □ Yes □No What?

On a scale of 1 to 5 (one = poor to five = excellent) describe your:

Upper body strength	1	2	3	4	5
Range of motion	1	2	3	4	5
Grip strength	1	2	3	4	5
Dexterity	1	2	3	4	5

Will you want your dog to help support you while you are walking or getting up?
If so, describe. _____

_____

Are you restricted in the use of your hands or arms? □ Yes □No

If yes, how so? _____

_____

Is one side of your body stronger than the other? □ Yes □ No □ Left □ Right

On which side would you want the dog to work most of the time? □ Left □ Right Why?

_____

Do you have spasms in your arms or legs? □ Yes □ No If so, how quickly do they pass?

Do you bruise easily? □ Yes □ No

Could a dog put his front legs up on your lap without hurting you? □ Yes □ No

Are you able to issue voice commands in a clear, audible voice? □ Yes □ No

Are you able to issue hand signals? □ Yes □ No

Is mobility limited? How? _____

Do you require the assistance of an aide or family member for daily living skills? □ Yes □ No

If so, what are that person's responsibilities (including the tasks they do for you or aid you to do, and number of hours worked per day)?

Name Hours Worked General Duties Telephone

_____

_____

_____

Are they willing to assist with the daily care of a Service Dog, if needed? □ Yes □ No

Do you anticipate future surgery or hospitalization for any reason? □ Yes □ No If yes, explain.

_____

_____

Do you have any cognitive difficulties (such as memory problems, inability to concentrate) that would affect your ability to manage a Service Dog? □ Yes □ No

If so, describe. _____

_____

Would any of your current medications impair your ability to manage a Service Dog or impact learning how to work with your dog?

_____

_____

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

Applicant signature_____ Date_____

Print Name _____ Relationship _____