Adult Autism Assistance Dog Application

Highland Canine Training, LLC
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Applicant Information

Name _____

Street Address _____

City _____ State _____ Zip _____

Home phone (___) _____ - _____ Cell (___) _____ - _____ Other (___) _____ - _____

Email Address _____

Preferred method of contact _____

Date of Birth _____ Sex - ☐ Male ☐ Female

Height _____'_____" Weight _____ lbs.

School Name *(if applicable)* _____

Street Address _____

City _____ State _____ Zip _____

Office phone (___) _____ - _____ County _____ District _____

How many hours per week is are you in school? _____

Doctor Name _____

Office Name (*if applicable*) _____

Street Address _____

City _____ State _____ Zip _____ Office phone (___) _____ - _____

Primary Diagnosis _____

Age at Time of Diagnosis _____

Secondary Diagnosis _____

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

_____

_____

_____

What types of therapies are you currently involved in?

_____

_____

_____

How many hours per week are you in therapies? _____

List medications, dosage, and frequency:

_____

_____

With whom do you live? _____

I currently reside in a ☐ House ☐ Apartment ☐ Duplex ☐ Other _____

Your residence currently has ☐ fenced yard ☐ enclosed area ☐ Other _____

Other people in home:

Name	Sex	Date of Birth

Do you have any current pets?

Species	Breed	Name	Age	Sex

Is anyone in your home allergic to dogs or pet dander? ☐ YES ☐ NO If yes, Who_____

Please indicate any of the following conditions that may apply. Describe behaviors, if necessary.

0 = Not Applicable, 1 = mild, 10 = severe

Seizures	0	1	2	3	4	5	6	7	8	9	10
Panic Attacks	0	1	2	3	4	5	6	7	8	9	10
Violence to your Self	0	1	2	3	4	5	6	7	8	9	10
Violence to Others	0	1	2	3	4	5	6	7	8	9	10
Violence to Property	0	1	2	3	4	5	6	7	8	9	10
Mood Swings	0	1	2	3	4	5	6	7	8	9	10

Hallucinations	0	1	2	3	4	5	6	7	8	9	10
Nightmares	0	1	2	3	4	5	6	7	8	9	10
Night Awakenings	0	1	2	3	4	5	6	7	8	9	10
Racing Thoughts	0	1	2	3	4	5	6	7	8	9	10
Medication Side Effects	0	1	2	3	4	5	6	7	8	9	10
Distractibility	0	1	2	3	4	5	6	7	8	9	10
Suicidal Behaviors	0	1	2	3	4	5	6	7	8	9	10
Self-stimulating Behaviors	0	1	2	3	4	5	6	7	8	9	10
Disassociation	0	1	2	3	4	5	6	7	8	9	10
Impulsivity	0	1	2	3	4	5	6	7	8	9	10
Poor Judgment	0	1	2	3	4	5	6	7	8	9	10
Self-care Deficits	0	1	2	3	4	5	6	7	8	9	10
Difficulty Managing Environment	0	1	2	3	4	5	6	7	8	9	10
Difficulty Completing Tasks	0	1	2	3	4	5	6	7	8	9	10

Please describe any of the behaviors or conditions listed above, if necessary.

_____

_____

_____

_____

_____

How do you see a service dog helping you?

_____

_____

_____

_____

_____

Have you previously owned a service or assistance dog? ☐ YES ☐ NO

Have you ever owned a dog in the past? ☐ YES ☐ NO

Who was responsible for the dog's training?

_____

Are you willing to participate in ongoing training sessions after receiving a service dog?

☐ YES ☐ NO

Will your family or housemates accept a trained dog as an equal partner in your house?

☐ YES ☐ NO

Please include any additional information that may be important for us to know.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

The information on this application is correct to the best of my knowledge. I understand that this preliminary application is required to be eligible for a packet application which will determine my suitability for a service dog. _____ (initials)

Applicant Signature _____ Date _____

Print Name _____