



Service Dog Application (Adult)

Highland Canine Training, LLC

145 Foxfield Drive

Harmony, NC 28634

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704.500.8281

1) Applicant Information (Required to be completed fully)

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.

College/University Name *(if applicable)* _____

Street Address _____

City _____ State _____ Zip _____

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

How many hours per week are you in school? _____

Do you plan to take your Service Dog to school with you? Y/N

Employer: Business Name *(if applicable)* _____

Street Address _____

City _____ State _____ Zip _____

Office phone (___) _____ - _____ Work hours _____

Do you plan to take your service dog to work with you? Y/N

2) Medical Information (Required to be completed fully)

Doctor Name/Specialty _____

Office Name *(if applicable)* _____

Street Address _____

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

Primary Diagnosis _____

Age at Time of Diagnosis _____

Secondary/Tertiary Diagnosis _____

Please describe the most significant symptoms of your disability/illness and how it affects you
(attach separate sheet if necessary):

Check any and all medical problems that apply:

- | | |
|---|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Alcohol or Drug Dependency | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Visual Impairment |
| <input type="checkbox"/> Other _____ | |

List any allergies (food, animals, material, etc.) _____

List medications (dosage and frequency): _____

Would any of your current medications impair your ability to manage a service dog or impact learning how to work with your dog? YES NO

If so, describe _____

Do you have any cognitive difficulties (such as memory problems, inability to concentrate, etc.) that would affect your ability to manage a service dog? YES NO

If so, describe _____

Do you have any visual difficulties (such as degraded peripheral vision, lack of vision in one eye, etc.) that would affect your ability to manage a service dog? YES NO

If so, describe _____

Do you have any speech difficulties that would affect your ability to manage a service dog?

YES NO

If so, describe _____

Do you require the assistance of an aide or family member for daily living skills? YES NO If so, list the responsibilities of each individual.

Name	Daily Hours	General Duties	Telephone

Are they willing to assist with the daily care of a service dog, if needed? YES NO

What types of therapies are you currently involved in? _____

How many hours per week are you in therapies? _____

Do you anticipate future surgery or hospitalization for any reason? YES NO

If so, explain. _____

Has there been any life changing events that has happened in the last 6 month? YES NO

If yes, explain

Do you anticipate any life changing events in the next year? YES NO

If yes, explain

a) Are you diagnosed with Autism/Downs Syndrome (if no, go to next section)

Please indicate any of the following conditions that may apply.

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

Also please indicate how often the occur.

N=Never, AN=Almost never, M=Monthly, W=Weekly, D=Daily, S=Multiple times a day

	0	1	2	3	4	5	6	7	8	9	10	How often	Example: 3, M
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	_____	
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.

b) Do you have mobility/stability issues (if no, go to next section)

Are you limited in your mobility? YES NO

If so, how? _____

Do you use a wheelchair? YES NO If yes: Electric type: _____ Manual

Do you use any other mobility aides? YES NO

If so, what? _____

Will you want your dog to help support you while you are walking or getting up? YES NO

If so, describe _____

Is one side of your body stronger than the other? YES NO Which side Left Right

On which side would you want the dog to work most of the time? (If you are right-handed, it is common for the dog to be trained to work on your left so your right hand can be free from leash, etc.)

Left Right

Why? _____

Are you restricted in the use of your hands or arms? YES NO

If so, describe _____

On a scale of 1-5 (1 = poor, 5= excellent), describe your:

<i>Upper body strength</i>	1	2	3	4	5
<i>Range of motion</i>	1	2	3	4	5
<i>Grip strength</i>	1	2	3	4	5
<i>Dexterity</i>	1	2	3	4	5

Are you able to issue hand signals? YES NO

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

c) Do you experience seizures (if no, go to next section)

What type of seizures do you have? _____

How often does seizure activity happen? _____

Describe what the seizures look like _____

Do you expect the dog to be trained for seizure alert and/or assistance? ___ Yes ___ No
If so, describe how you see the dog helping? _____

d) Are you hard of hearing or have hearing loss (if no, go to next section)

Describe the extent of your hearing loss (full, partial, both ears, one ear L/R, etc.)

Do you use any hearing aids? Yes/No If Yes, which types _____

To what sounds would you like your dog to alert to? _____

Are you able to give verbal commands? Yes No
Would you like your dog to be trained on verbal or hand signals? Verbal/Hand Signals

e) Do you have psychiatric issues (if no, go to next section)

What are your triggers? _____

Are there any indications (either verbal or visual) that you do before having a panic attack, anxiety, night terrors, etc. (e.g. rubbing thighs, scratching head, hyperventilating, etc.)?
If yes, please describe _____

Please indicate any of the following conditions that may apply.

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

Also please indicate how often the occur.

N=Never, AN=Almost never, M=Monthly, W=Weekly, D=Daily, S=Multiple times a day

												How often	Example: 3, AN
Panic Attacks	0	1	2	3	4	5	6	7	8	9	10	_____	
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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.

3) Lifestyle Information (Required to be completed fully)

I currently reside in a House Apartment Duplex Other _____

Your residence currently has fenced yard enclosed area Other _____

With whom do you live? _____

Other people in home:

Name	Sex	Date of Birth	Relationship

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, Whom _____

Where do you currently sleep? _____

What size is your bed (King, Queen, etc.)? _____

How high off the floor is your bed (in feet)? _____

Where in the room will the Service dog be sleeping (in bed, on floor, in crate, etc.) _____

Will the dog be allowed on the furniture/bed? Y/N

When do you get out of bed in the morning? _____

What time do you retire? _____

What type of recreational activities do you do and how often? _____

Where do you like to go out in public? _____

Do you see yourself travelling a lot with your service dog? YES NO

What type of transportation do you see using (e.g. plane, car, bus, etc. please be specific with the frequency of each) _____

4) Service Dog Requirements (Required to be completed fully)

How do you see a service dog helping you?

Do you have a preference for a dog breed? YES NO

If yes, which breed/type (e.g. Hypoallergenic, Labrador, etc.) and why?

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

Who was responsible for the dog's training?

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

If so, explain.

Do you have any experience working with animals? YES NO

If so, explain.

After receiving your service dog, what are your hopes, goals, and fears?

Where will the dog exercise and have playtime? _____

Where will the dog be taken for toilet requirements? _____

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

Describe your definition of exercise. _____

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

Name _____ Phone _____

Proximity to your home _____

Do you have any concerns regarding owning a service dog? YES NO

If so, describe. _____

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 _____