

**CANINE HELPERS FOR THE HANDICAPPED, INC.
INDIVIDUAL MEDICAL HISTORY FORM**

Please sign below and forward to your primary physician. Any questions regarding this form should be directed to Canine Helpers for the Handicapped, Inc., 5699 Ridge Road, Lockport, NY 14094, 716-433-4035.

If minor, or under guardianship or ward of the court, parent or duly authorized guardian is required to sign pursuant to state and federal law.

Full name _____

Signature _____

Relationship _____

Agency _____ Phone _____

Agency address _____

Please release to Canine Helpers for the Handicapped, Inc. any requested information regarding my condition. This information will not be used for any other purpose than to evaluate and assess my situation in making a successful canine placement and assisting me with ancillary services. Canine helpers will keep this information confidential and will not share it with anyone.

Applicant's Signature: _____

Patient's name: _____

Address: _____

Doctor's name: _____

Address: _____

_____ Phone: _____

Physical Evaluation

Date of last examination _____

Length of association with client _____

Primary conditions _____

Description of limitation _____

Secondary condition _____

Description of limitation _____

Additional limitations _____

Are two or more limbs impaired? _____ Describe _____

Estimated duration of significant impairment (s) _____

Prognosis and effect of condition on individual's ability to perform activities of daily living _____

Activities of daily living (ADL) shall refer to the ability to meet personal care needs, i.e. Feeding, toileting, dressing, etc., As well as the ability to perform tasks necessary for independent living, i.e., Manage finances, maintain home, acquire needed outside services.)

Related medical history: _____

Mental/Emotional Evaluation

(Please Answer Yes Or No)

- A. Able to exercise judgment and make decisions necessary for ADL _____
- B. Able to sustain attention spans _____
- C. Manifesting inappropriate behavior beyond his/her control _____
- D. Able to control physical or motor movement sufficient to sustain ADL _____
- E. Capable of perception and memory to the degree necessary to sustain ADL _____
- F. Able to follow directions and learn to the degree necessary to sustain ADL _____
- G. Under medication which impairs functioning _____
- H. Capable of decisions regarding personal or others' needs and safety _____

Was incapacity due to or affected by alcoholism or drug abuse? _____ If so:

- A. Has patient been accepted into treatment facility? _____

If yes, when? _____

- B. Has organic damage resulted? _____

- C. Does patient constitute a danger to him/herself? _____ To others? _____

- D. Has patient refused treatment or referral to treatment center? _____

Additional comments: _____

In what ways do you feel this individual might benefit from a Canine Helper? _____

Can you recommend this individual for a Canine Helper placement? _____

Would you feel that Canine Helpers for the Handicapped might benefit from a consultation with you? _____

If so, in what areas? _____

Additional comments or remarks: _____

Signature of physician _____

Date _____