221 N. Grampian Hills Rd.
Columbia, SC 29223
(803) 788-7063
info@paals.org / www.paals.org

Client Applicant Medical History

Please Note: A medical history form is required from each of your physicians and/or therapists.

Instructions

This form should be completed and signed by your physician/therapist. A medical history form is required from each of your physicians and/or therapists. The completed forms should be mailed to PAALS at

PAALS
221 N. Grampian Hills Rd.
Columbia, SC 29223

Information Release

Date _____

Dr. _____ ,

Please release the requested medical information regarding my condition to Palmetto Animal Assisted Life Services (PAALS). This information will be used to help determine my abilities in regards to the placement of a service dog**.**

Applicant's Name (please print) _____

Applicant's Signature _____

Physician Information

Name _____

Type of practice _____

Address _____ **County** _____

City _____ **State** _____ **Zip Code** _____

Phone Numbers *Work* _____ *Cell* _____ *Fax* _____

E-Mail _____

PALMETTO ANIMAL ASSISTED LIFE SERVICES

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Patient Medical Information

(to be completed by physician or therapist)

What is this patient's primary disability? _____

_____

What is the cause of this disability? _____

_____

At what age was the patient disabled? _____

Are there significant secondary disabilities? *Yes* ❑ *No* ❑

If yes, please describe _____

_____

Is this disability progressive? *Yes* ❑ *No* ❑

Is the patient's incapcity due to alcohol or drug abuse? *Yes* ❑ *No* ❑

The effects of this patient's disability include (PLEASE CHECK ALL THAT APPLY)

Deafness	❑	*Speech Impairment*	❑	*Reduced Stamina*	❑
Hearing Loss	❑	*Coordination Problems*	❑	Limited Mobility	❑
Memory Loss	❑	*Spasticity*	❑	*Delayed Development*	❑
Vision Impairment	❑	*Muscular Weakness*	❑		

Other _____

Does this patient have trouble with (PLEASE CHECK ALL THAT APPLY)

Allergies	❑	*Chronic Pain*	❑	*Heightend Emotions*	❑
Depression	❑	*Seizures*	❑	*Balance*	❑
Brittle Bones	❑	*Hot/Cold Sensitivity*	❑		

Does this patient use any of the following aids or assistive devices (PLEASE CHECK ALL THAT APPLY)

Prosthesis	❑	*Wheelchair - Manual*	❑	*Leg Brace*	❑
Wrist Brace	❑	*Wheelchair - Power*	❑	*Hearing Aid*	❑
Crutch/Cane	❑	*Walker*	❑		

Other _____

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Is this patient… (PLEASE CHECK MOST APPROPRIATE ANSWER) [ADL = Activities of Daily Living]

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 or 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 ❑

Do you feel PAALS might benefit from a consultation with you? *Yes* ❑ *No* ❑

Comments _____

_____

_____

_____

_____

_____

_____

_____

_____

Physician/Therapist Signature _____

Print Name _____

Date _____