



# Pawsitive Purpose

Dog Training and Behavior

## SERVICE DOG APPLICATION TRAIN YOUR OWN DOG

DATE: \_\_\_\_\_

### CLIENT INFORMATION:

FIRST NAME: \_\_\_\_\_ LAST NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: (HOME) \_\_\_\_\_ (CELL) \_\_\_\_\_

EMAIL: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED

### PERSONAL INFORMATION:

TYPE OF HOME: ☐ HOUSE ☐ APARTMENT ☐ OTHER: \_\_\_\_\_

HOW MANY FAMILY MEMBERS LIVE IN THE HOME: \_\_\_\_\_

DO YOU HAVE A GOOD SUPPORT SYSTEM: ☐ YES ☐ NO

### LIST ALL PERSONS LIVING IN THE HOME:

NAME \_\_\_\_\_ AGE \_\_\_\_\_

NAME \_\_\_\_\_ AGE \_\_\_\_\_

NAME \_\_\_\_\_ AGE \_\_\_\_\_

NAME \_\_\_\_\_ AGE \_\_\_\_\_

NAME \_\_\_\_\_ AGE \_\_\_\_\_

NAME \_\_\_\_\_ AGE \_\_\_\_\_

ARE THERE PEOPLE WHO PERIODICALLY STAY WITH YOU? (EXTENDED FAMILY, FRIENDS, AIDE, NURSE, ETC). \_\_\_\_\_ IF YES, PLEASE LIST:

NAME \_\_\_\_\_ AGE \_\_\_\_\_

NAME \_\_\_\_\_ AGE \_\_\_\_\_

NAME \_\_\_\_\_ AGE \_\_\_\_\_

NAME \_\_\_\_\_ AGE \_\_\_\_\_

ARE THERE OTHER PETS IN THE HOME: \_\_\_\_\_. IF YES, PLEASE LIST:

NAME: \_\_\_\_\_ SPECIES: \_\_\_\_\_ AGE: \_\_\_\_\_

NAME: \_\_\_\_\_ SPECIES: \_\_\_\_\_ AGE: \_\_\_\_\_

NAME: \_\_\_\_\_ SPECIES: \_\_\_\_\_ AGE: \_\_\_\_\_

NAME: \_\_\_\_\_ SPECIES: \_\_\_\_\_ AGE: \_\_\_\_\_

NAME: \_\_\_\_\_ SPECIES: \_\_\_\_\_ AGE: \_\_\_\_\_

### LIFESTYLE INFORMATION:

### GIVE AN EXAMPLE OF A TYPICAL DAILY SCHEDULE:

[illegible]

**EMPLOYER:** \_\_\_\_\_

SUPERVISOR'S NAME AND PHONE NUMBER: \_\_\_\_\_

RESPONSIBILILITES: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

WORK SCHEDULE (DAYS / HOURS WORKED): \_\_\_\_\_

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PLACES YOU FREQUENTLY GO: \_\_\_\_\_

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HOW DO YOU LEARN BEST: ☐ LISTENING ☐ READING ☐ DOING

**MEDICAL INFORMATION:**

HOW IS YOUR OVERALL HEALTH? \_\_\_\_\_

\_\_\_\_\_

DO YOU: ☐ DRINK ALCOHOL? ☐ SMOKE? ☐ TAKE ILLEGAL DRUGS?

**PHYSICIANS:**

PRIMARY PHYSICIAN: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_

**OTHER PHYSICIANS YOU SEE FOR YOUR DISABILITY:**

PHYSICIAN: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_

PHYSICIAN: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_

PHYSICIAN: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_

HAS YOUR PHYSICIAN RECOMMENDED YOU NEED A SERVICE DOG? ☐ YES ☐ NO

DISABILITY/DIAGNOSIS: \_\_\_\_\_

IS YOUR DISABILITY: ☐ PROGRESSIVE ☐ STABLE

HOW DOES YOUR DISABILITY AFFECT YOU? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

PHYSICAL OR MENTAL LIMITATIONS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

MEDICATIONS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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SIDE EFFECTS YOU EXPERIENCE FROM MEDICATION: \_\_\_\_\_

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CURRENT THERAPIES / TREATMENTS BEING USED: \_\_\_\_\_

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WILL THERE BE A THIRD-PARTY HANDLER? \_\_\_\_\_ IF YES, PLEASE LIST:

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ RELATION: \_\_\_\_\_

WHAT DO YOU NEED THE DOG TO DO FOR YOU? (TASK WORK)

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IS THERE ANYTHING ELSE YOU WOULD LIKE US TO KNOW ABOUT YOU OR YOUR  
DISABILITY? \_\_\_\_\_

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**DOG INFORMATION:**

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ SPAYED/NEUTERED? \_\_\_\_\_

BREED OR MIX: \_\_\_\_\_

WHERE DID YOU ACQUIRE YOUR DOG? \_\_\_\_\_

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HOW LONG HAVE YOU HAD YOUR DOG? \_\_\_\_\_

HOW OLD WAS YOUR DOG WHEN YOU ACQUIRED HIM/HER? \_\_\_\_\_

SOCIALIZATION HISTORY: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

TRAINING HISTORY: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

VETERINARIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_

DATE OF LAST VACCINATIONS: DHPP \_\_\_\_\_ BORDETELLA \_\_\_\_\_

RABIES \_\_\_\_\_ CANINE INFLUENZA \_\_\_\_\_ OTHER \_\_\_\_\_

CURRENT OR PAST SURGERIES: \_\_\_\_\_

\_\_\_\_\_

CURRENT OR PAST MEDICATIONS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

CURRENT OR PAST MEDICAL CONDITIONS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

HAS YOUR DOG SHOWN ANY AGGRESSION, ANXIETY, OR FEAR? \_\_\_\_\_

IF YES, PLEASE DESCRIBE: \_\_\_\_\_

\_\_\_\_\_

By signing below, you are confirming that the information provided above is accurate, complete and up to date.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date