



### Medical History Form

Please ask your physician or therapist to complete this form. Sign the release below and ask your physician to return it directly to Bodhi Battalion.

Patient's Last name \_\_\_\_\_ First \_\_\_\_\_ Sex: \_\_\_ Date of Birth \_\_\_\_\_

#### Release of Medical Information

I authorize \_\_\_\_\_ to release information regarding my condition to Bodhi Battalion. This information will be used to evaluate and assess my situation and is essential for Bodhi Battalion to custom train a service dog according to my physical and/or mental health needs.

Printed name \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_

To the Physician or Therapist:

If you have questions, please contact the Bodhi Battalion:

JoAnna McTevia 720-550-2677 joanna@bodhibattalion.org

Please mail the completed form to:

Bodhi Battalion PO Box 906 Broomfield CO 80038

Practitioner's Name: \_\_\_\_\_ Specialty: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Date of last examination: \_\_\_\_\_ Length of association with patient: \_\_\_\_\_

What is the patient's primary diagnosis?

\_\_\_\_\_ What other conditions/diagnoses does the patient have? \_\_\_\_\_

The prognosis for the duration of impairment(s):

\_\_\_\_\_

Prognosis for progression of impairment(s):

\_\_\_\_\_

Prognosis for lifespan:

\_\_\_\_\_

Daily medications (please list):

\_\_\_\_\_

\_\_\_\_\_

How severe is the patient's mobility impairment? (Please circle)

None    Need assistive device    Need full-time care

How severe is the patient's cognitive impairment?

None    Often    need assistance    Need full-time care

Do limitations affect the patient's ability to control their behavior?

Normal    Moderate    Poor self-control

How effective is the patient at handling and overcoming their limitations?

Ineffective    Moderate    Very competent

How reliable is the patient – on time for appointments, compliant with medications, etc.?

Unreliable    Moderate    Very reliable

\* Activities of Daily Living (ADL) refers to the ability to meet personal care needs, i.e., feeding, bathing, dressing, etc., as well as the ability to perform tasks necessary for independent living, i.e., be compliant with therapy and medications, manage finances, maintain home, acquire outside services.

To what degree do limitations affect patient's ability to perform Activities of Daily Living\*(ADL):

Normal    Moderate    Severe

Is incapacity due to or affected by the patient's alcoholism or drug abuse?     Yes     No

A. Has patient ever been in treatment facility?     Yes     No

    If yes, when and duration? \_\_\_\_\_

B. Has permanent damage resulted?     Yes     No

C. Has the patient refused treatment or a referral to a treatment center?     Yes     No

Bodhi Battalion dogs may be skilled at the following tasks:

    Enhance balance while walking

    Enhance balance while going up or downstairs

    Provide brace for transfers or getting up from floor/chair

    Assist in pulling a wheelchair

    Retrieve adaptive equipment

    Carry items in mouth or backpacks

    Take things to another person

Specialized tasks as needed by the client; e.g., assist with laundry, get the mail, tug shoes or coat off

    Manners and obedience

    Retrieve dropped articles

    Push Lifeline or 911 button

- Find and retrieve phone
- Find help
- Retrieve from refrigerator
- Push handicap buttons
- Turn lights off and on
- Open and close doors

Bodhi Battalion Service dogs have good manners and basic obedience. Their job is to provide assistance with tasks and companionship. Your patient will gain control of part of their lives and receive unconditional love. Are there other ways in which you think your patient would benefit from receiving a Bodhi Battalion dog? If so, please describe:

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Can you recommend that this patient receive a Bodhi Battalion dog?  Yes  No  
Why or Why Not? \_\_\_\_\_

Do you feel that the client is capable of properly caring for a service dog? This would include the daily physical needs of the dog as well as the substantial financial commitment a service dog requires. (we estimate \$2000/yearly)  No  Yes  
May we contact you with questions?  No  Yes

Additional Comments or Remarks:

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Signature of physician or therapist: \_\_\_\_\_ Date: \_\_\_\_\_