

K9 Healing Warriors

Service Dog Program
for wounded warriors



Intake Packet

www.heartbeatforwarriors.org

(425)931-1047

Heartbeat Serving Wounded Warriors®

PO Box 610

Onalaska, WA 98570





Dear Veteran,

Welcome to K9 Healing Warriors.

Thank you for your courage in serving our country. You are the plumb line of excellence for this country!!

Thank you for your interest in our Owner Train Service Dog Program, K9 Healing Warriors. It is an honor to hopefully serve you with this program. Our commitment to your complete success with this program is 100%. I realize the intake packet is long, but it allows us a way to serve you and your dog better or, if need be, to assist in finding a dog for you.

Heartbeat Serving Wounded Warriors®, K9 Healing Warriors program will be responsible for paying all training and equipment fees for this program. We work with Cascade Service Dogs in Olympia WA, who provides outstanding training in this Service Dog program. This program is unique in that we train the Warrior and his/her own dog that he/she has already established a relationship with.

Please feel free to contact me with any questions prior to completing this intake packet.

A COMPLETED INTAKE PACKET INCLUDES:

- 1) THE INTAKE PACKET, FILLED OUT AND SIGNED.**
- 2) A PROFESSIONAL LETTER OF REFERENCE FROM A THERAPIST, SOCIAL WORKER, COUNSELOR, PHYSICIAN, PSYCHOLOGIST, OR PSYCHIATRIST STATING A SERVICE DOG WOULD PROVIDE A BENEFIT TO YOU AND YOUR DAILY LIVING WITH REGARD PTSD, TBI AND/OR PHYSICAL INJURIES.**
- 3) A COPY OF YOUR DD-214.**
- 4) A COPY OF MILITARY MEDICAL BOARD OR A VA RATING LETTER CONFIRMING INJURIES.**
- 5) THREE REFERENCE LETTERS (FROM FRIENDS, RELATIVES, BOSS, ETC.) REGARDING HOW THEY SEE A TRAINED SERVICE DOG WOULD BENEFIT THE WARRIOR.**
- 6) VETERAN MUST HAVE BEEN INJURED/WOUNDED DURING COMBAT DEPLOYMENT DURING GWOT TO INCLUDE FIRST GULF WAR, OIF, OEF.**



VETERAN AGREES TO:

- 1) Bring his/her dog, no older than four (4) year of age, to be evaluated for your training by Sharon at Cascade Service Dogs.
- 2) Dog must be spayed or neutered by one (1) year of age, current on vaccinations and exam, and provide a copy.
- 3) Team (Veteran and dog) will train 180-300 hours for 9-12 months, as determined by the Team's progress.
- 4) Team will attend a minimum of two 1-hour training classes per week.
- 5) Team will practice 1-2 hours a day on their own with instructions given during class.

By signing below, you agree to the above.

Name

Date



Heartbeat Serving Wounded Warriors®

Contact Information

K9 Healing Warriors



Janice Buckley, President

Janice@hearbeatforwarriors.org

(425)931-1047



Warriors Personal Data Sheet

GENERAL INFORMATION

Date: _____

Name: _____ Rank/Grade: _____

Branch of Military:

- USAF USN USA USMC USCG
 Active Duty Reserve Guard IRR Retired

MOS when deployed: _____ Date of Birth (MM/DD/YYYY): _____

Age: _____ Weight (lbs): _____ Height: _____ Feet: _____ Inches _____ Blood Type: _____

Local Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Phone No: _____ Cell Home Work Message

Permanent address is same as local address

Permanent Address: _____ City: _____ State: _____

Zip: _____ Phone No: _____ Cell Home Work Message

DEPENDENTS

Marital Status: Married Single Divorced Separated

Spouses Name: _____

Children: Number: _____ Ages: _____

IN CASE OF EMERGENCY

Name: _____

Address: _____ City: _____ State: _____

Zip: _____ Phone No: _____ Cell Home Work Message



Describe the obstacles/challenges you encounter at home and in the community:

Are you anticipating a life change in the next year? Yes No

If yes, please describe:

Do you live in a House Apartment Other

Do you anticipating a move within the next year? Yes No

SERVICE DOG INFORMATION

Have you ever had a service dog? Yes No

Describe the accommodations for your dog at home and work, if you are employed:

Describe your fenced yard:

4 foot wood fence 6 foot wood fence No fence

4 foot chain link fence 6 foot chain link fence Other: _____

Is your yard completely fenced? Yes No

What is your current means of support? _____

Current annual income:

Less than \$10,000 \$10,000 - \$20,000 \$20,000 - \$30,000 \$30,000 - \$40,000

\$40,000 - \$50,000 \$50,000 - \$60,000 \$60,000 - \$70,000 \$70,000 - \$100,000

Can you support the cost of a service dog's food and health care?

(between \$700-\$1,000 per year) Yes No

How many hours a day will your service dog be alone? _____

Please explain: _____



Do you plan to take your service dog to work with you? Yes No

If yes, have you already discussed this with your employer? Yes No

Does your employer have any concerns about you bringing your service dog with you? Yes No

Please describe what your employer is concerned about: _____

Are you able to perform everyday tasks such as:

Feeding yourself? Yes No

Dressing yourself? Yes No

Personal hygiene? Yes No

Maintain your own residence? Yes No

Manage your own finances? Yes No

Utilize outside services? Yes No

If you answered no to any of the above tasks, who does these things for you? _____

Are you, or is anyone you live with, allergic to dogs? Yes No

If yes, to what extent? _____

Do you have any animals **in your home** at this time? Yes No

Please list all animals (name, age, type of animal, etc.) _____

Do you have any outdoor animals? Yes No How many? _____

What kind? _____



Medical History Form

GENERAL INFORMATION

Name _____ Date of birth (MM/DD/YYYY) _____

Age _____ Male Female

Address _____ City _____ State _____

Zip _____ Phone No. _____ Cell Home Work Message

HEALTH / ACCIDENT INSURANCE COMPANY

DAN TRICARE VA Other (specify): _____

Primary Sponsor Name: _____ Policy No. _____

HEALTH HISTORY

Please fill in the bubbles as indicated below:

Do you currently have, or have you ever been treated for any of the following?:

Yes	No	Condition/Injury	Explain
<input type="checkbox"/>	<input type="checkbox"/>	Asthma Last attack: (MM/YY) <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Last HbA1c: (%) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> . <input type="checkbox"/> <input type="checkbox"/> %	
<input type="checkbox"/>	<input type="checkbox"/>	Hypertension (high blood pressure)	
<input type="checkbox"/>	<input type="checkbox"/>	Heart disease/heart attack/chest pain/heart murmur	
<input type="checkbox"/>	<input type="checkbox"/>	Stroke/TIA	
<input type="checkbox"/>	<input type="checkbox"/>	Lung/respiratory disease	
<input type="checkbox"/>	<input type="checkbox"/>	Ear/sinus problems	
<input type="checkbox"/>	<input type="checkbox"/>	Muscular/skeletal condition	
<input type="checkbox"/>	<input type="checkbox"/>	Menstrual problems (women only)	
<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric/psychological	
<input type="checkbox"/>	<input type="checkbox"/>	Behavioral/neurological disorders	
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding disorders	
<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells	
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	
<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	
<input type="checkbox"/>	<input type="checkbox"/>	TBI/Migraines/Headaches	
		How injured:	
<input type="checkbox"/>	<input type="checkbox"/>	Sickle cell disease	
<input type="checkbox"/>	<input type="checkbox"/>	Seizures Last seizure: (MM/YY) <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Sleep disorders (e.g., sleep apnea)	Use CPAP: <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal/digestive problems	
<input type="checkbox"/>	<input type="checkbox"/>	Surgery Last surgery: (MM/YY) <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Serious injury	
<input type="checkbox"/>	<input type="checkbox"/>	Excessive fatigue or shortness of breath w/ exercise	
<input type="checkbox"/>	<input type="checkbox"/>	Other	



HEALTH HISTORY *(continued)*

Loss of arm strength: (Please check the level that you are generally at each day)

Right arm: Mild loss Moderate loss Severe loss No loss

Left arm: Mild loss Moderate loss Severe loss No loss

Loss of fine motor skills in your hands:

Right hand: Mild loss Moderate loss Severe loss No loss

Left hand: Mild loss Moderate loss Severe loss No loss

Do you have any vision loss that can NOT be corrected with glasses? Yes No

If yes, please explain: _____

Reaction Speed: Normal Slightly impaired Moderately impaired Severely impaired

Endurance: High No limitations Moderate Mild

Balance: Normal Mildly impaired Moderately impaired Severely impaired

Cold sensitivity: Normal Impaired

Heat sensitivity: Normal Impaired

Oral speech is: Clear Distorted but understandable

Few people can understand me other than family No speech at all

My speech is: High-pitched Low-pitched

Do you use a wheelchair? Yes No Manual Electric

How much time do you spend in the wheelchair each day? _____

If your wheelchair is electric, where is the control panel located? _____



HEALTH HISTORY *(continued)*

For each item, on a scale of one (does not limit daily function) to 10 (fully limits daily function) answer each of the following:

	1	2	3	4	5	6	7	8	9	10	N/A
Distractibility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intrusive imagery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disassociation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flashbacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feelings of isolation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hyper vigilance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Startle response	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Avoidance behaviors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nightmares	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feelings of being threatened	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aggression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

List all medications you are on now:

Please fill in the bubbles as indicated below:

Are you allergic to or do you have any adverse reaction to any of the following?:

Yes	No	Allergies or Reaction to	Explain
<input type="checkbox"/>	<input type="checkbox"/>	Medication	
<input type="checkbox"/>	<input type="checkbox"/>	Food, Plants or insect bites	



Warrior Statement

BY SIGNING BELOW, I CERTIFY THAT ALL THE ANSWERS ARE FULL AND COMPLETE.

WARRIOR SIGNATURE: _____ DATE: _____



Service Dog Tasks

Service dog tasks you require to mitigate your disability: (Please check all that apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> Space management | <input type="checkbox"/> Awake from nightmares |
| <input type="checkbox"/> Open/Close doors | <input type="checkbox"/> Agoraphobia | <input type="checkbox"/> Medication reminder |
| <input type="checkbox"/> Mood swings | <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Provide bracing to stand/walk/sit/balance |
| <input type="checkbox"/> Other : _____ | | |

Do you use any equipment as a result of your disability? (Please check all that apply)

- Crutches Cane Walker Brace Prosthetics Wheelchair



Release of Liability

I save and hold harmless said training and related parties of Heartbeat Serving Wounded Warriors, K9 Warriors, Cascade Service Dogs from any claim or lawsuit by me, my family, estate, heirs, or assigns, arising out of my enrollment and participation of this course including claims arising during or after I receive my training.

I have read and understood this agreement, and agree to be bound by it.

Signature of Participant _____ Date ____/____/____



Emergency Authorization

During field oriented programs, emergencies may develop at any time, and these emergencies may necessitate medical care, hospitalization, blood transfusions or surgery. If possible, a Heartbeat Serving Wounded Warriors® representative or Cascade Service Dogs will contact parents, guardians or personal physicians prior to such treatment. However, such contact may not be possible, depending on the nature of the emergency. Therefore, by initialing here, I authorize K9 Healing Warriors program, through the Heartbeat Serving Wounded Warriors®, or its representatives or agents, to secure medical treatment, anesthesia and surgery if needed. I understand that payment for any medical services is solely my responsibility.

Please initial here to indicate that you have read and fully understand this paragraph: _____.

Please list the name, numbers and relationship of persons you wish to be contacted in the event of an emergency.

Name _____ Relationship _____
Address _____ City _____ State _____

Zip _____ Phone No. _____ Cell Home Work Message

Alternate Name _____ Relationship _____

Address _____ City _____ State _____

Zip _____ Phone No. _____ Cell Home Work Message

Primary care physician name and phone numbers

Name _____

Address _____ City _____ State _____

Zip _____ Phone No. _____ Cell Office



Interview / Photo Release Form

I authorize Heartbeat Serving Wounded Warriors® (herein “HB”) to use and permit others to use my image, voice, likeness, picture, video (collectively, “image”) in all forms and media including composite or modified representations for all purposes, including educational and commercial, throughout the world and in perpetuity. I waive the right to inspect or approve versions of my image used for distribution or publication, or the written copy that may be used in connection with my image. I understand that my name will not be used unless I so authorize below. I further understand that I will not be compensated for the permission that I am granting here.

In giving this permission, I am not limited by any other agreement that I have entered into.

I release HB (including its officials, employees, representatives, agents, licensees, successors, and assigns) from any claims that may arise regarding the use of my image, including any claims of defamation, invasion of right to privacy, infringement of moral rights, rights of publicity or personality, or copyrights.

I have read and understood this agreement and I am over the age of 18. This agreement expresses the complete understanding of the parties.

Signature of participant _____ Date ____/____/____

Printed name of participant _____

With my initials, I authorize Heartbeat Serving Wounded Warriors® to use my name in association with my image.

**** TO THE WARRIOR: YOU ARE NOT UNDER ANY PRESSURE TO SIGN THIS IN ORDER TO TAKE THE K9 HEALING WARRIORS CLASSES BY HEARTBEAT SERVING WOUNDED WARRIORS® ****