



welcome

Client information

Date: _____

Owner (Last Name First): _____

Address: _____

City: _____ State: _____ Zip: _____

E-mail Address: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Co-Owner/Spouse (Last Name First): _____

E-mail Address: _____ Phone: (_____) _____

Emergency Contact Name: _____ Phone: (_____) _____

How did you learn about our practice? _____

Number of pets (please specify by type) _____

Primary reason for visit: _____

Pet information

Pet's Name: _____ Dog Cat Other _____

Sex: M F Age: _____ Birthdate: _____ Breed: _____

Color: _____ Neutered/Spayed: Yes No At what age? _____

What age was pet obtained? _____

From: Friend Breeder Pet Shop Humane Society Other _____

Reason for obtaining pet (check all that apply) Companion Protection Breeding
 Show Other _____

Describe your pet's diet: _____

List your pet's current medication: _____

Please check any symptoms or problems you've noticed with your pet:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Appetite Loss | <input type="checkbox"/> Gagging | <input type="checkbox"/> Sneezing | <input type="checkbox"/> Behavioral Changes |
| <input type="checkbox"/> Gums Bleeding | <input type="checkbox"/> Thirst | <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Limping |
| <input type="checkbox"/> Urination Increase | <input type="checkbox"/> Coughing | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Scooting | <input type="checkbox"/> Weakness | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Scratching | <input type="checkbox"/> Eye Disorders: _____ | <input type="checkbox"/> Shaking Head | <input type="checkbox"/> Other: _____ |

Pet's History (check all that pet has received)

- | | | |
|---|---|---|
| <input type="checkbox"/> Distemper | <input type="checkbox"/> Feline Leukemia Test | <input type="checkbox"/> Prior Surgery: _____ |
| <input type="checkbox"/> Parvovirus (Dog) | <input type="checkbox"/> FVRCP (Infectious Disease-Cat) | <input type="checkbox"/> Prior Illness: _____ |
| <input type="checkbox"/> Rabies (Dog/Cat) | <input type="checkbox"/> Dental | <input type="checkbox"/> Other: _____ |

Authorization

I hereby authorize the veterinarian to examine, prescribe for, or treat the above described pet. I assume responsibility for all charges incurred in the care of the animal. I also understand that ALL PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED.

Signature of client responsible for pet(s) _____ Date _____