



# 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 \_\_\_\_\_