

# 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"/> Other: _____       |
| <input type="checkbox"/> Eye Disorders: _____ | <input type="checkbox"/> Shaking Head    |   |

### 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 \_\_\_\_\_

