

# Welcome

## Client Information

Date: \_\_\_\_\_ Email Address: \_\_\_\_\_

Name (Last Name First): \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_

Work 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    | <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 \_\_\_\_\_