

# Welcome to Our Practice



## Client Information

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you learn about our practice? \_\_\_\_\_ E-mail \_\_\_\_\_

Number of pets (please specify what types) \_\_\_\_\_

Primary reason for visit? \_\_\_\_\_

## Pet Information

Pet's Name: \_\_\_\_\_  Dog  Cat  Other \_\_\_\_\_

Sex:  Female  Male Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Breed: \_\_\_\_\_

Color: \_\_\_\_\_ Neutered/Spayed:  Yes  No At what age? \_\_\_\_\_

What age was your pet obtained? \_\_\_\_\_ From: \_\_\_\_\_

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

Describe your pet's diet: \_\_\_\_\_

List your pet's current medications: \_\_\_\_\_

### Please check any symptoms of 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 Vaccination History

- |                                     |   |   |
|-------------------------------------|---|---|
| <input type="checkbox"/> Distemper  | <input type="checkbox"/> Feline Leukemia Test | <input type="checkbox"/> Prior Surgery: _____ |
| <input type="checkbox"/> Parvovirus | <input type="checkbox"/> FVRCP                | <input type="checkbox"/> Prior Illness: _____ |
| <input type="checkbox"/> Rabies     | <input type="checkbox"/> Dental Cleaning      | <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 responsible client: \_\_\_\_\_ Date: \_\_\_\_\_