

Welcome to our clinic



Client Information

Date: _____ Social Security #: _____ Birthdate: _____
Name (Last Name First) _____
Address: _____ City/State/Zip: _____
Home Phone: (____) _____ Employer: _____
Work Phone: (____) _____ Employer's Address: _____
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 _____