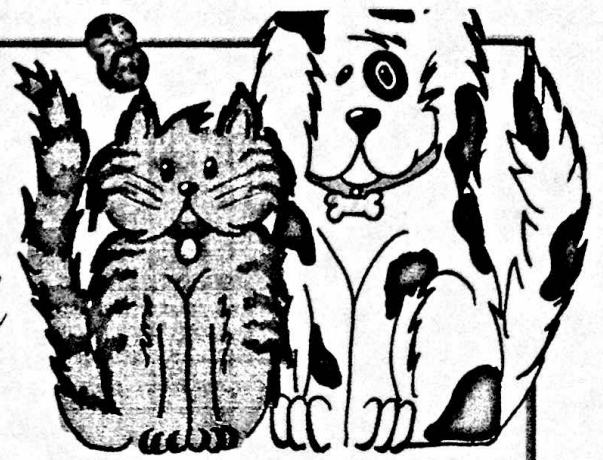


# Welcome to our clinic



## Client Information

Date: \_\_\_\_\_ **EMAIL** \_\_\_\_\_  
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 \_\_\_\_\_