

CLIENT INFORMATION

PLEASE FILL OUT COMPLETELY

PLEASE PRINT

Last Name: _____ First Name: _____

Spouse's Name: _____

Address: _____ City, State, Zip: _____

Home phone (area code): (____) - _____ Other phone (Pager / Cellular): _____

Place of Employment: _____ Phone: (____) - _____

Spouse's Employment: _____ Phone: (____) - _____

Spouse other phone (____) - _____

Driver's License # (If you are paying by check): _____ *(Indicate self or spouse)*

PATIENT INFORMATION

Pet Name: _____ (circle which): **Dog** **Cat** **Other**

Breed: _____ Color: _____

Date of Birth or Age: _____ Sex (circle): **M** **F** Is your pet neutered/spayed **Y** **N**

Please give approximate dates of the following routine medical care:

Dogs

Cats

Heartworm test: _____ Feline Leukemia/FIV test: _____

On heartworm preventative: **YES** **NO** Leukemia vaccine: _____

Distemper vaccine: _____ Distemper vaccine: _____

Rabies vaccine: _____ Rabies vaccine: _____

Please be sure we have both of the following:

Referring Veterinarian and Clinic names: _____

Regular Veterinarian and Clinic names: _____

Please fill out the reverse side as well as you can. The information you provide will enable us to understand and therefore take better care of you pet.

Where did you obtain your pet (*breeder, pet store, stray, etc.*)? _____

How long have you owned your pet? _____

Where is your pet housed? (Circle) Indoors Outdoors Both

Intended purpose of your pet? (Circle) Pet Show Sport Guard Support

For intact females:

When, approximately, was your pet's last heat cycle? _____

For neutered/spayed pets:

When, approximately, was the surgery performed? _____

What is your pet's current diet? (*Include brand*) _____

	Yes	No	?
1) Does your pet have contact with other animals?	_____	_____	_____
2) Has your pet ever been out of the St. Louis Metro area?	_____	_____	_____
3) Is your pet currently receiving any medications?	_____	_____	_____
4) Has your pet had any bad reactions to a medication?	_____	_____	_____
5) Has your pet had any illness, injury, or surgery prior to the current problem?	_____	_____	_____
6) Is your pet currently coughing or sneezing?	_____	_____	_____
7) Has there been any recent change in your pet's willingness to exercise?	_____	_____	_____
8) Has there been a recent change in your pet's appetite?	_____	_____	_____
9) Has your pet lost or gained weight recently?	_____	_____	_____
10) Is your pet currently vomiting?	_____	_____	_____
11) Has there been any recent change in your pet's bowel movement?	_____	_____	_____
12) Have there been any recent change in you pet's urinary habits?	_____	_____	_____
13) Have you noticed a change in the amount of water your pet drinks?	_____	_____	_____

If you answered yes to any of the above questions please put the corresponding number and explain: _____

Understand that all payments are due at time of service. There is a deposit required on most procedures and the balance is due at time of patient discharge or completion of service.

Signature of Owner or Agent

Date