



WELCOME TO OUR CLINIC!

CLIENT INFORMATION

Thank you for giving us the opportunity to care for your pet. We'll be happy to answer any questions you have about your pet's health. To insure the best care possible, please take a moment to fill in this form completely. Thank you.

Date _____

Owner Name(s) _____

Address _____

City _____ State _____ Zip _____

Spouse/Other _____

Email (for sending vaccine reminders ONLY) _____

Home Phone () _____ Cell # () _____ Work # () _____

Emergency Contact _____

How did you learn about our hospital? Yellow Pages Recommendation
 Sign New Neighbor Mailing

Number of pets: Dogs _____ Cats _____ Other (specify) _____

PET HEALTH HISTORY

Name of Pet _____ Dog Cat Other: _____

Breed _____ Color _____ Age _____

Male Neutered Female Spayed

Vaccination History (Date & type of last vaccinations) _____

Please check (✓) any symptoms or problems that you have noticed about your pet.

<input type="checkbox"/> Appetite Change	<input type="checkbox"/> Lethargic	<input type="checkbox"/> Wound/Cut
<input type="checkbox"/> Behavior Problems	<input type="checkbox"/> Limping	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Breathing Problems	<input type="checkbox"/> Loss of Balance	_____
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Scratching	_____
<input type="checkbox"/> Eye Problem	<input type="checkbox"/> Urination Problem	_____
<input type="checkbox"/> Ear Problem	<input type="checkbox"/> Vomiting/Gagging	_____

Pet's Current medications: _____

Diet/Amount fed: _____

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 this animal. I also understand that these charges will be paid at the time of release.

Signature of Owner _____ Date _____