



**Pet Owner/Client Information:**

**Welcome New Clients**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Main phone: ( ) \_\_\_\_\_ Other: ( ) \_\_\_\_\_ Spouse's#: ( ) \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Driver's License number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

**How did you learn about us?** \_\_\_\_\_ **If personal referral, whom may we thank?** \_\_\_\_\_

**Pet Information: (For more than one pet, ask for additional pet form)**

Pet's Name: \_\_\_\_\_ Species: Dog \_\_\_ Cat \_\_\_ Breed: \_\_\_\_\_ Color: \_\_\_\_\_ Microchip #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: Male \_\_\_ Female \_\_\_ Neutered or Spayed: \_\_\_\_\_

Pet's Diet: \_\_\_\_\_ Any special diets: \_\_\_\_\_

List current medications and/or medical conditions: \_\_\_\_\_

List any previous illnesses or surgeries: \_\_\_\_\_

Does your pet have any allergies? \_\_\_\_\_

Has your pet had heartworm testing? On prevention medication (what kind) \_\_\_\_\_

Is your pet on flea and tick prevention (what kind) \_\_\_\_\_

**Please check any symptoms your pet is currently showing:**

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> coughing           | <input type="checkbox"/> urination decrease/increase | <input type="checkbox"/> behavioral changes    | <input type="checkbox"/> rash                     |
| <input type="checkbox"/> sneezing           | <input type="checkbox"/> scooting                    | <input type="checkbox"/> limping               | <input type="checkbox"/> loss of balance/weakness |
| <input type="checkbox"/> breathing problems | <input type="checkbox"/> vomiting                    | <input type="checkbox"/> shaking head or ears  | <input type="checkbox"/> unusual mass             |
| <input type="checkbox"/> diarrhea           | <input type="checkbox"/> appetite loss               | <input type="checkbox"/> scratching or itching | <input type="checkbox"/> eye problems             |
| <input type="checkbox"/> constipation       | <input type="checkbox"/> change in activity level    | <input type="checkbox"/> change in thirst      | <input type="checkbox"/> cut or injury            |

Describe any other areas of concern: \_\_\_\_\_

**\*\*Please bring in a stool specimen so we can check for parasites\*\***

**Authorization:**

*I authorize the veterinarian to examine, treat, or prescribe for my pet(s). I assume responsibility for all charges incurred in the care of the animal(s). I also understand that all professional fees are due at the time services are rendered.*

**Returned check fee: \$20**

**Signature of client responsible for the pet(s):** \_\_\_\_\_ **Date:** \_\_\_\_\_