



REHABILITATION CLIENT INFORMATION

Your Name: _____ Home Phone: _____

Address: _____ Cell Phone: _____

City: _____ State: _____ Zip: _____

Email Address: _____ Preferred Method of Contact? _____ (home, cell or email)

Please ensure that the email address is legible and complete. If you change your home address, your email address, or telephone number, please update us as soon as possible to ensure continued communications.

Employer: _____ Employer Phone: _____

Alternate Contact: _____ Alternate Phone: _____

Name of referring veterinarian? _____

We pledge to do our very best to care for your pet. In return we ask that you accept responsibility for charges incurred in the treatment of your pet and accept that **payment is due when services are rendered**. Please feel free to ask for an estimate of the treatment plan prior to receiving services.

Agreement Terms: A fee of \$30 will be charged for all checks returned unpaid. Additional fees will be charged if your account is turned over to collections.

If appointment is booked, a 24 hour cancellation notice is required to avoid a no show fee of \$50.00

By signing below, you agree that you are the owner of the patient you have presented to us for treatment and that you will personally assume responsibility for all charges incurred. You also understand that medical records pertaining to your pet's treatment will be sent to the referring veterinarian and will become a part of your pet's permanent medical history.

Client Signature: _____ **Date:** _____

Client Name: _____

PET INFORMATION

Pet's Name: _____ Age or Birthday: _____ Species: _____

Breed: _____ Color _____ Markings: _____ Male ___ Female ___

Is your pet Spayed/Neutered? Yes ___ No ___ Is your pet known to bite? Yes ___ No ___

Known Medical Conditions: _____

Current Medications: _____

Tell us about your pet's daily life:

Other Noteworthy Information About Your Pet:

Client Name: _____

DETAILED PET INFORMATION

Pet's Name: _____

Today's Date: _____

What is the reason for your visit today? What symptom that your pet is having are you most concerned about? _____

When did you first notice the symptom or issue? _____

Please list any other **current** issues: _____

Please list any **previous**, major health concerns: _____

- Please pick one of these five descriptions that best describes your pet's personality:
- Easy going, loves everyone, laid back, easily satisfied, patient, social, slow reaction to strangers.
- Fearful, quiet, independent, one person pet, shy, smart, runs away from strangers.
- Well-behaved, obedient, likes a routine, problem solver, ignores strangers.
- Dominant, very active, moves fast, competitive, stubborn, gets mad when he/she doesn't get their way, barks at strangers.
- Excitable, hard to calm down, likes to be center of attention, mischievous, wags tail for strangers.

Please check all boxes below that describes your pet:

<input type="checkbox"/> Decreased appetite	<input type="checkbox"/> Back pain	<input type="checkbox"/> Pet prefers to sleep in warm/sunny locations
<input type="checkbox"/> Increased appetite	<input type="checkbox"/> Limping	<input type="checkbox"/> Pet prefers to sleep in cool/shady locations
<input type="checkbox"/> Vomiting	<input type="checkbox"/> Weight loss	<input type="checkbox"/> Painful, if so, where?
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Coughing	<input type="checkbox"/> _____
<input type="checkbox"/> Constipation	<input type="checkbox"/> Sneezing	<input type="checkbox"/> Pants when resting
<input type="checkbox"/> Increased thirst	<input type="checkbox"/> Vision problems	<input type="checkbox"/> Restless, doesn't sleep at night
<input type="checkbox"/> Decreased thirst	<input type="checkbox"/> Hearing problems	<input type="checkbox"/> Bleeding at any location, or blood in stool or urine
<input type="checkbox"/> Lumps on body	<input type="checkbox"/> Fatigue/lethargy	<input type="checkbox"/> Behavioral problems
<input type="checkbox"/> Urinary incontinence	<input type="checkbox"/> Bad breath	
<input type="checkbox"/> Itchy skin	<input type="checkbox"/> Dry skin	
<input type="checkbox"/> Smelly ears or discharge	<input type="checkbox"/> Greasy/smelly skin	