

Your Pet(s) Care Team

Veterinarian

Veterinarian

<i>Primary:</i> <i>Clinic:</i> <i>Address:</i> <i>City/State/Zip:</i> <i>Telephone:</i> Practice is primarily traditional ___ or holistic ___ in approach? <i>Applies to which pets?</i>	<i>Secondary:</i> <i>Clinic:</i> <i>Address:</i> <i>City/State/Zip:</i> <i>Telephone:</i> Practice is primarily traditional ___ or holistic ___ in approach? <i>Applies to which pets?</i>
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Chiropractor

Acupuncture

Trainer

Behaviorist

<i>Name:</i>				
<i>Clinic:</i>				
<i>Phone:</i>				
<i>Applies to which pets?</i>				

Veterinary Specialist

Veterinary Specialist

Energy Work

Daycare

<i>Name:</i>				
<i>Specialty:</i>				
<i>Phone:</i>				
<i>Applies to which pets?</i>				

Groomer

Boarding Facility

Other

Other

<i>Name:</i>				
<i>Facility:</i>				
<i>Phone:</i>				
<i>Applies to which pets?</i>				

Do we have permission to contact the above caregivers if the situation warrants it?

Yes Please (All Above) Initials: _____ No Please (All Above) Initials: _____

Yes, all except for:

Initials: _____

Signature: _____

Date: _____

Signature: _____

Date: _____

Pet # ___ of ___

(Complete 1 for each pet you would like help with)

Pet Name:	Species: <input type="checkbox"/> Bird <input type="checkbox"/> Cat <input type="checkbox"/> Dog <input type="checkbox"/> Horse <input type="checkbox"/> Other:
Breed:	Color: Markings:
DOB:	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Intact <input type="checkbox"/> Spayed <input type="checkbox"/> Neutered
Age When Acquired:	Acquired From: <input type="checkbox"/> Breeder <input type="checkbox"/> Friend <input type="checkbox"/> Rescue Group/Individual <input type="checkbox"/> Found
Known History Prior to Acquisition:	
Diet History and how being fed now:	
Medical History & Current Health Concerns:	

Training/Behavior History & Concerns

<p>Class or Private Obedience Training Received:</p> <p><input type="checkbox"/> Puppy Kindergarten <i>Where Attended:</i> _____</p> <p><input type="checkbox"/> Basic Obedience <i>Where Attended:</i> _____</p> <p><input type="checkbox"/> Intermediate Obed <i>Where Attended:</i> _____</p> <p><input type="checkbox"/> Advanced Obedience <i>Where Attended:</i> _____</p> <p><input type="checkbox"/> Canine Good Citizen <i>Where Attended:</i> _____</p> <p><input type="checkbox"/> Tricks <i>Where Attended:</i> _____</p> <p>Skills Attained:</p> <p><input type="checkbox"/> Sit/Stay <input type="checkbox"/> Heel <input type="checkbox"/> Off</p> <p><input type="checkbox"/> Down/Stay <input type="checkbox"/> Leave It <input type="checkbox"/> On Leash Only Control</p> <p><input type="checkbox"/> Come <input type="checkbox"/> Take It <input type="checkbox"/> Off Leash Control Obtained</p> <p><input type="checkbox"/> Place/Bed <input type="checkbox"/> Loose Leash Walking</p> <p><input type="checkbox"/> High Five <input type="checkbox"/> Bow <input type="checkbox"/> Retrieve <input type="checkbox"/> Roll Over</p> <p><input type="checkbox"/> Play Dead <input type="checkbox"/> Pray <input type="checkbox"/> Other (Please Describe)</p> <p>On Leash Skills Good With <input type="checkbox"/> Distance <input type="checkbox"/> Duration <input type="checkbox"/> Distraction <input type="checkbox"/> Ummm, not so much?</p> <p>Off Leash Skills Good With <input type="checkbox"/> Distance <input type="checkbox"/> Duration <input type="checkbox"/> Distraction <input type="checkbox"/> Now I KNOW you're kidding!</p> <p>Crate Trained? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, stays in crate overnight?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Avg # of Hours?</i> _____</p> <p><i>In crate during daytime?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Avg # of Hours?</i> _____</p> <p><i>Does he/she have accidents in the crate?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, are these typically</i> <input type="checkbox"/> bowel movements <input type="checkbox"/> urine</p> <p>Comments:</p>	<p>Competition/Sport Training/Experience:</p> <p><input type="checkbox"/> Novice <input type="checkbox"/> Rally-O</p> <p><input type="checkbox"/> Open <input type="checkbox"/> Freestyle</p> <p><input type="checkbox"/> Utility <input type="checkbox"/> Canine Disc</p> <p><input type="checkbox"/> Herding <input type="checkbox"/> Carting</p> <p><input type="checkbox"/> Tracking <input type="checkbox"/> Weight Pulling</p> <p><input type="checkbox"/> Conformation <input type="checkbox"/> Protection</p> <p><input type="checkbox"/> Earth Dog <input type="checkbox"/> Dock Diving</p> <p><input type="checkbox"/> Field <input type="checkbox"/> Other (Please Describe)</p> <p>Cool Stuff</p> <p>Is Your Dog a Therapy Dog? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, which group?</i> _____</p> <p>Is Your Dog a Service Dog? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Very Cool, what type?</i> _____</p> <p>Comments:</p>
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Behavioral Concerns

(Please explain where needed in detail on the back)

Nipping: ___ People ___ Dogs Have injuries been caused? ___ Yes ___ No

Biting: ___ People ___ Dogs Have injuries been caused? ___ Yes ___ No

*Attacking/Fighting Dogs: # of fights ___
of times caused injuries ___ # of times received injuries ___*

*Barking at ___ People ___ Dogs ___ Squirrels
___ Postal/Delivery Workers ___ Bicycles ___ Cats
___ What doesn't he bark at?
___ Barks only appropriately in my opinion*

*Chewing: ___ Furniture ___ Shoes ___ Clothing ___ Plants
___ The House ___ Only His/Her Own Stuff
___ Chews anything he/she can!*

Counter Surfing ___ Never ___ Frequently ___ At Will, Help!

*House Training ___ Never an accident ___ Occasionally an accident
___ Oh, he's SUPPOSED to go outside??? Help!*

Leash Walking ___ Does well ___ No, he/she rips my arm off!

Jumping ___ On People ___ On Furniture ___ Over Fences

Doors ___ Waits at door ___ Escapes out the door

What Have We Forgotten To Ask?

Additional Information You Feel We Need To Know or Concerns You Have:

Signature: _____

Date: _____

Signature: _____

Date: _____