

Client Information Form



Owner Information

Owner First Name(s): _____

Owner Last Name(s): _____

Full postal address: _____

Primary Phone: _____ cell work home

Secondary Phone: _____ cell work home

Email: _____

Pet Information

Pet Name: _____ Male Female

Breed: _____ Spayed/neutered: Yes No

Birthdate (mm/dd/yy): _____ Kenneled at home: Yes No

Personality & Behaviors: (please check all that apply)

Animal aggression Anxiety Difficulties with Grooming: _____

Stranger aggression Biting/Nipping _____

Leash/Kennel aggression Social Butterfly _____

Medical Information

Primary Care Center: _____ Business phone: _____

Full postal address: _____

Common Conditions: (please check all that apply)

Blindness Skin conditions/sensitivities Dental conditions

Deafness Chronic ear infections Anal gland issues

Epilepsy/seizures Diabetes Heart conditions

Allergies Past injuries/operations Gut conditions

If yes to any of the above, please give details: _____

*** By signing below, you hereby verify that the above information is correct and valid, to the best of your knowledge:**

Signature: _____ **Date:** _____

*** Please attach a copy of your pet's most recent rabies vaccination form to this packet ***