 Patient History

Date:

**Pet Guardian Name: ­­­­­­­­­­­­**

Address and Phone Number:­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address:

Veterinarian:

**Patient Name:**

Breed:

M/F Spayed/Neutered Age: Weight:

**Patient History:**

Food Sensitivities:

Vaccination History and most recent dates:

Medical History: (please contact your primary veterinarian and have records emailed to drsue@thrivepetvet.com)

Medications:

Current Supplements:

Temperature Preference: Warm Cold No preference

Sleep: Sleeps well up at night (and at what times):

**Goals for this consultation:**

1.

2.

By submitting this form, I understand that any nutrition or supplement advice given to me by Dr. Sue Howell is not intended to diagnose or treat any medical condition related to my pet. Rather, recommendations made are in the interest of supporting my pet’s healthy body function and body balance.