



Patient's name:

Owner's name:

Household members

Adults (names/ages):

Children (names/ages):

Dogs (name/age/breed):

Cats (name/age/breed):

Other pets:

Home environment

Number of outside stairs:

Number of inside stairs:

Pool yes no

Hot tub yes no

Flooring type:

Type of pet bed:

Home alterations already made for your pet (ie: stair gates, throw rugs, ramps):

Patient's lifestyle

____ Non-mobile

____ Couch potato

____ Active house pet

____ Competitive athlete

 Which sport _____

____ Working dog

 Type of work _____

____ Running partner

 Miles per run _____

Patient information

Breed:

Age:

Gender: Male Male/neutered
 Female Female/spayed

Weight:

Allergies/drug reactions:

Family veterinarian:

Clinic name:

Which veterinarian referred you?

How did you hear about us?

Current activity level:

Type & length of daily exercise (ie: walking on leash, 2 miles a day, on paved roads, 5 days per week; hikes in woods, off leash for 2 hours each weekend):

Desired activity level following rehabilitation:

Commands/tricks already trained:
sit stand down stay crawl bow back
roll-over beg wave other: _____

Behavior on leash: calm wild pulls

Diet

Current food:

Number of meals per day:

Volume of food per meal:

Type of treats given:

Table scraps given? yes no

Any recent weight loss? yes no

Previous medical history

Dietary supplements:

Medications:

Previous illness or injuries:

Previous treatments or surgeries:

Recent test results

Blood or urine tests:

X-rays:

OFA/Penn Hip Results:

MRI or CAT Scan:

Have you noticed any unusual behaviors or changes in daily routine?

Current Medical Conditions:

Infections	Yes	No
Skin wounds	Yes	No
Breathing problems	Yes	No
Heart problems	Yes	No
Pace maker	Yes	No
Seizures/epilepsy	Yes	No
Cancer	Yes	No
Skin lumps	Yes	No
Pregnant	Yes	No
Bone plates/pins	Yes	No
Recent cortisone injection	Yes	No
Recent bleeding	Yes	No
Vomiting or diarrhea	Yes	No

Reason for visit today:

When did it start? _____

Progression: Better Worse Unchanged

Severity 1-10 (0-normal, 5-moderate, 10-very severe): _____

Current pain level 1-10 (0-no pain, 5- moderate pain, 10- severe pain): _____

Bladder control: normal incontinent

Bowel control: normal incontinent

What makes it worse? Running, jumping, stairs, exercise, cold weather,

Other: _____

What makes it better? Exercise, rest, warmth, supplements, medicines,

Other: _____

Any other information we should know?

