Patient History Intake Form

Client Name:_____ Patient Name:_____

Email Address:_____ Phone Number:_____

Patient visit information: Check or Circle All That Apply

Vomiting	Diarrhea	Coughing	Sneezing	Drinking more
Decreased appetite	Decreased Activity	Itching	Rashes	Urinating more
Limping : Front/rear Right/Left	Eye discharge : L/R Squinting : L/R Rubbing : L/R	Shaking head: Itching ear(s)	Other:	

Diet: Name/Variety/Canned or Dry/ Amount and Frequency of meals

_____

_____

_____

List ALL medications given including Over the Counter supplements, Heartworm Prev, Flea and tick Prev. Please include dosages and frequency of Administration:

_____

_____

_____

Describe the medical complaint including: when it started/ changes over time/ improvement or worsening:

_____

_____

_____

_____

_____

Use the back of the page if needed.