

# WELCOME TO NORTHSIDE VETERINARY CLINIC

233 Berry Street Brooklyn, NY 11211 718-387-0541



## Client Information

Date \_\_\_\_\_ Email \_\_\_\_\_

Name (Last Name First) \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Employer \_\_\_\_\_

Work Phone (\_\_\_\_) \_\_\_\_\_ Employer's Address \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Phone \_\_\_\_\_

How did you learn about our practice? \_\_\_\_\_

Number of pets (please specify by type) \_\_\_\_\_

Primary reason for visit \_\_\_\_\_

## Pet Information

Pet's Name \_\_\_\_\_  Dog  Cat  Other \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Breed \_\_\_\_\_

Color \_\_\_\_\_ Neuter/Spayed  Yes  No At what age? \_\_\_\_\_

What age was pet obtained? \_\_\_\_\_

From  Friend  Breeder  Pet Shop  Humane Society  Other \_\_\_\_\_

Reason for obtaining pet (check all that apply)  Companion  Protection  Breeding  Show  Other \_\_\_\_\_

Describe your pet's diet \_\_\_\_\_

List your pet's current medications \_\_\_\_\_

### Please check any symptoms or problems you've noticed with your pet:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Appetite Loss       | <input type="checkbox"/> Gagging         | <input type="checkbox"/> Sneezing           |
| <input type="checkbox"/> Behavioral Changes  | <input type="checkbox"/> Gums Bleeding   | <input type="checkbox"/> Thirst             |
| <input type="checkbox"/> Breathing Problems  | <input type="checkbox"/> Limping         | <input type="checkbox"/> Urination Increase |
| <input type="checkbox"/> Coughing            | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Vomiting           |
| <input type="checkbox"/> Depression          | <input type="checkbox"/> Scooting        | <input type="checkbox"/> Weakness           |
| <input type="checkbox"/> Diarrhea            | <input type="checkbox"/> Scratching      | <input type="checkbox"/> Other _____        |
| <input type="checkbox"/> Eye Disorders _____ | <input type="checkbox"/> Shaking Head    | <input type="checkbox"/> Other _____        |

### Pet's History (Check all that pet has received):

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Distemper        | <input type="checkbox"/> Feline Leukemia Test           | <input type="checkbox"/> Prior Surgery |
| <input type="checkbox"/> Parvovirus (Dog) | <input type="checkbox"/> FVRCP (Infectious Disease-Cat) | <input type="checkbox"/> Prior Illness |
| <input type="checkbox"/> Rabies (Dog/Cat) | <input type="checkbox"/> Dental                         | <input type="checkbox"/> Other _____   |

## Authorization

I hereby authorize the veterinarian to examine, prescribe for, or treat the above described pet. I assume responsibility for all charges incurred in the care of the animal. I also understand that ALL PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED. NO CHECKS PLEASE. THANK YOU.

Signature of client responsible for pet(s) \_\_\_\_\_ Date \_\_\_\_\_

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