VETERINARY SURGICAL CENTERS REHABILITATION

Client/Patient Registration Form

DATE_____ **Client#** _____

Client Registration

Owner _____

Address_____

City _____ State _____ County _____ Zip _____

Cell _____ Home _____ Work _____

Email _____

Secondary Contact_____ Cell _____

Active Military ? (must provide military ID) Yes ☐ No ☐

How did you hear about us?

☐ Friend/Family_____ ☐ Veterinary Professional (please fill fields below):

☐ Event_____ Veterinarian Name: _____

☐ Magazine_____ Hospital Name: _____

☐ Google ☐ Yelp ☐ Facebook ☐ Other_____

☐ Internal Referral _____

Patient Registration

Name of Pet _____ Nickname _____

Species _____ Breed _____ Color _____

Date of Birth _____ Sex _____ Approximate weight at 2 years _____

Occupation (Companion, Law enforcement, Agility, etc…) _____

Cats: FIV/Felv tested? ☐ Yes ☐ No If so, when_____ Results_____

Cats/Dogs: Heartworm tested? ☐ Yes ☐ No If so, when_____ Results_____

Does your pet have any allergies? ☐ Yes ☐ No If so, allergic to_____

_____

_____

Primary Care Veterinarian

Veterinarian's Name _____

Hospital Name _____

Phone Number_____

Specialist Seen (Previously)

Veterinarian's Name _____

Hospital Name _____

Phone Number_____

Specialist Seen (Previously)

Veterinarian's Name _____

Hospital Name _____

Phone Number_____

Preferred Pharmacy

Pharmacy's Name _____

Pharmacy's Location _____

Phone Number_____

Pet History

Why are we seeing your pet today? _____

_____

_____

Under what circumstances did you first notice the condition and how long ago? _____

_____

_____

Does anything seem to aggravate the condition and has it gotten worse or better over time? _____

_____

_____

Have radiographs been taken for this current condition? ☐ Yes ☐ No

If yes, where? _____

_____

Has your pet had recent bloodwork within the last 6 weeks? ☐ Yes ☐ No

If yes, where? _____

_____

Please describe your pet's diet _____

_____

Please mark any signs or problems you have noticed in your pet:

☐ Skin Problems	☐ Increased Thirst	☐ Breathing Problems
☐ Staring into Space	☐ Increased Urination	☐ Coughing/Gagging
☐ Exercise Intolerance	☐ Diarrhea/Vomiting	☐ Wheezing
☐ Fainting/Collapsing	☐ Change in Appetite	☐ Tongue turning blue
☐ Weakness	☐ Weight Loss	☐ Bleeding Problems
☐ Loss of Balance	☐ Allergies	☐ Limping: ☐ Right ☐ Left ☐ Back ☐ Front
☐ Difficulty on Stairs	☐ Trouble Sleeping	☐ Difficulty Getting Up/Down Furniture
☐ Loss of Muscle Mass	☐ Seizure	☐ Difficulty getting in/out of car
☐ Lyme Disease	☐ Circling/Pacing	☐ Other _____

_____

Is your pet's rabies vaccine up to date? ☐ Yes ☐ No

Do you feel your pet is currently at a healthy weight? ☐ Yes ☐ No

Has your pet seen a rehabilitation specialist for the presenting problem? ☐ Yes ☐ No

If yes, when and where? _____

_____

Please list all current medications below:

Medication Name	Dose Given	Frequency	Doctor Prescribed By

Did any of these medications help? ☐ Yes ☐ No

If yes, please describe _____

_____

_____

Has your pet had any previous surgeries? ☐ Yes ☐ No

If yes, please list: _____

_____

_____

Has your pet had any previous complications with anesthesia? ☐ Yes ☐ No

If yes, please describe: _____

_____

_____

When was your pet's last meal given? Date _____ Time _____

Are you aware of any metal such as implants or hardware or in your pet? ☐ Yes ☐ No

If yes, describe _____

_____

_____

Is there any other pertinent information you feel the doctor should know? _____

_____

_____

Have you or anyone in your household had any cold or flu-like symptoms in the last 14 days including a fever?
☐ Yes ☐ No

Have you or a member of your household traveled out of the country in the last 14 days? ☐ Yes ☐ No

Have you or a member of your household tested positive for COVID-19? ☐ Yes ☐ No

Is your pet ☐ Indoor ☐ Outdoor ☐ Indoor and Outdoor?

If you pet goes outside, has your pet been within 6 feet of other pets or people not living in the household?

☐ Yes ☐ No

Has your pet shown any respiratory signs such as coughing, sneezing, nasal discharge or fever in the last 7 days?

☐ Yes ☐ No

Signature _____ Date _____