REHABILITATION THERAPY PATIENT HISTORY FORM

Pet's Guardian/Owner:___________________________ Today's Date:___________
Phone numbers:____
Email: ____

Is it ok if we email you reminders? Yes/ No (please circle one)

Pet's Name: _________________________ Breed: ____________________________
Age:______________ Weight: ________________ Sex: M/F spayed/neutered: y/n

Regular Veterinarian: ____
Approximate date of last vet visit: _________________

How did you hear about us? ____

What is the main problem we are seeing you for today?_________________________

PET HISTORY

1. Please describe housing/habits: _ Indoor/outdoor _ Indoor only
_ Outdoor supervised/fenced yard _ Outdoor only _ Allowed to roam
_ Attends public parks, kennels, groomer, pet shows, etc.
_ Travels out of the state? If yes, please note where: :__________________________________

2. Current activity level: _ Very active/athletic _ Normal _ Inactive _ Hyperactive
Has this activity changed in the past year? □Yes □no
Please describe current activities (and previous activity if different)- i.e. frequency of walks, time or length of walks, hikes, agility, hunting, etc.:
____
____
____
____

3. Nutrition:
Current brand of food or recipe if homemade:________________________________
Cups per day__________________________
My pet is fed ____________ times per day or food is always out (please circle one)
Treats/table scraps offered throughout the week:
____
____
____
____
I believe my pet's weight is □ideal □ too heavy □too lean

Are you interested in nutritional counseling: □ yes □ no

Appetite is: _ Normal _ Decreased _ Excessive
Water Consumption _ Normal _ Decreased _ Excessive

4. Behaviors- Does your pet:
_ Yes _ No Exhibit lameness or abnormal gait?
_ Yes _ No Show changes in stamina or respiratory pattern/rate?
_ Yes _ No Have itchy, scaly, or oily skin, or hair loss?

_ Yes _ No Have difficulty or slowness on the stairs?
_ Yes _ No Have trouble jumping (i.e. in/out of car)?
_ Yes _ No Like to swim?
_ Yes _ No Has your dog harmed or shown aggression towards any other person or dog?
What motivates your pet? (i.e. food, tennis ball, squeaky toy, etc.)_________________________

Please elaborate below if needed for #5

6. Please list any major past, chronic, or ongoing medical problems:

____
____
____
____

7. Current medications: dose and frequency (please include supplements)

____
____
____
____
____

8. What are your concerns/goals for today's evaluation? Please indicate the highest priority.

____
____
____
____

Date of onset:_________________
Progression since issue was first noted: □better □worse □about the same
What treatments have you tried? Please note if they made the issue better, worse, or no change.

____
____
____
____

9. How much time do you have each day to do home exercise/therapy with your pet?___________________

10. What are your long term goals for your pet's activity?

____
____

Please draw a tick mark on the following line to indicate the severity of your pet's pain today (0= no pain, 10= severe pain)
0---10

If you need to elaborate on anything or if there are any other concerns the doctor/staff should be aware of, please elaborate here:

Thank you!