Welcome to Animal Hospital of Colorado Springs

Client Information

For Check Writing Privileges

First Name:	Last Name:	SS#
Spouse (co-owner)Name:	Last Name:	SS#:
Street Address:	Apt:	City/State/Zip:
Home Phone:	Cell Phone:	E-Mail Address
Place of Employment:	May we contact you there?	Work #:
Place of Employment (spouse):	May we contact you there?	Work #:

How did you become aware of our hospital? Yellow Pages: Dex ☐ Yellow Book ☐ Other ☐
Clinic Sign ☐ Referral☐ Internet ☐ Search Engine Used: ___________________________
Humane Society ☐
If referred whom may we thank? ____
Please list the name and phone number of the last clinic your pet was seen at:

____

Pet Information

Name:	DOB:	Species:
Breed:	Sex: M ☐ F ☐	Sterilized ("fixed")? Y ☐ N ☐
Color:	Markings:	Microchip #:

Dog Vaccination History:

Date of Last Vaccinations:____
Vaccines Given: DAPP (distemper/parvo) ☐ Rabies 1 year ☐ 3 year ☐
Inbd (kennel cough) ☐ Giardia ☐
Other:__________________
Does your dog go hiking or around lakes? Y ☐ N ☐
Does your dog engage in the following activities (please circle all that is applicable): boarding, doggy daycare, grooming, or dog parks? Y ☐ N ☐
Do you test your dog for heartworm? Y ☐ N ☐
What heartworm prevention do you use for your dog?____

Cat Vaccination History:

Date of Last Vaccinations____
Vaccines Given: FECVRC (distemper combo) ☐ Rabies 1year ☐ 3 year ☐
Feline Leukemia ☐ Giardia ☐
Does your cat go outside? Y ☐ N ☐

Has your cat ever been tested for (please circle if applicable): Feline Leukemia, FIV, FIP?
Result:____

Health History: Please check the corresponding box(es), if your pet has had problems with any of the following areas:

Weight loss	☐	Excessive Scratching	☐
Weight gain	☐	Hair loss	☐
Poor appetite	☐	Poor hair coat/dry skin	☐
Increased appetite	☐	Scooting	☐
Diarrhea	☐	Thyroid	☐
Vomiting	☐	Diabetes	☐
Constipation	☐	Heart Murmur	☐
Decreased Urination	☐	Aggressive behavior	☐
Increased Urination	☐	Destructive behavior	☐
Loose stools	☐	Disobedience	☐
Increased thirst	☐	Difficulty hearing	☐
Refusal to drink	☐	Difficulty with vision	☐
Discharge/odor from ears	☐	Allergies	☐
Lumps on body	☐	Urinating/defecating outside of box/ in house	☐
Blood in urine/stool	☐	Seizures	☐
Muscular/joint stiffness	☐	Bloating	☐
Difficulty w/t stairs	☐	Limping (please specify which leg(s) below):	
Lethargic	☐	Right Side Front ☐ Rear ☐	
Hyperactive	☐	Left Side Front ☐ Rear ☐	
Discharge from eyes	☐		
Coughing/sneezing	☐		
Wheezing/panting	☐		

What food is your pet currently on?____
How much do you feed your pet per day?____
Do you brush your pet's teeth? Y ☐ N ☐
Has your pet ever had a professional dental cleaning? Y☐ N☐
If "yes," date of last dental__________________________ Clinic dental done at _____________________
Please list any medications your pet is currently taking:

____

Are there any special concerns that you would like addressed at today's exam?
____

I, the undersigned, am the owner, or agent for the owner, of the animal described above. I authorize Animal Hospital of Colorado Springs to perform diagnostics, anesthesia, surgery and treatment as prescribed. I agree to pay all fees required by the attending veterinarian when services are rendered. I realize I cannot be guaranteed a successful outcome. I agree to pick up the pet when requested and understand the animal may be declared abandoned after three days if not claimed.
Outstanding accounts will be charged a rate of 18% per annum on the unpaid balance, starting on the date the services were performed.

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Signature Date