



HOSPITAL USE ONLY	Wt:
	Room#:
	Time:

# Patient Intake Form

## Client Information

<b>First Name:</b>	<b>Last Name:</b>	<b>M.I.:</b>	<b>Add'l Owner(s):</b>
<b>Mailing Address:</b>			
<b>City:</b>	<b>State:</b>	<b>ZIP:</b>	
<b>Home Phone:</b>	<b>Work Phone:</b>	<b>Cell Phone:</b>	
<b>E-mail:</b>	<b>Employer:</b>		
<b>How did you hear about us?</b>	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Walk-In	<input type="checkbox"/> Friend — Their Name <input type="checkbox"/> Other
<b>Referring Veterinarian:</b>	<b>Family Veterinarian (if different):</b>		

## Patient Information

<b>Pet's Name:</b>	<b>Species:</b>	<input type="checkbox"/> Canine	<input type="checkbox"/> Feline	<input type="checkbox"/> Other
<b>Breed:</b>	M <input type="checkbox"/>	Neutered <input type="checkbox"/>	<b>Color:</b>	<b>Birthdate or Age:</b>
	F <input type="checkbox"/>	Spayed <input type="checkbox"/>		
<b>Initial Presenting Problem:</b>				

### TREATMENT AUTHORIZATION and INFORMATION/PHOTO RELEASE

I hereby authorize VRCC practices to perform medical and initial diagnostic/surgical procedures on my pet as required for diagnosis and treatment. I understand that I can terminate treatment at any time by contacting the doctors and assistants.

If I have been referred to this hospital by another veterinarian, I understand that they will require a summary of the care and treatment provided by the VRCC practices in order to ensure that my pet's care can be continued without interruption. I also understand that VRCC considers the identification of a referring veterinarian by me to be my authorization to release records and information to that veterinarian.

We are leaders and teachers in the veterinary medical field, thus case information and/or photos may be used in teaching, forms, continuing education, Web site, veterinary literature, and the like. I authorize the release of case/patient information for such purposes; patient confidentiality (names withheld) will be maintained.

In the event I sell this pet to another owner, I authorize release of medical information to the new owner, should they request it.

### FINANCIAL POLICY

Payment is due as services are rendered. For hospitalized cases, a deposit is required in advance. The balance is due upon discharge from the hospital. You may pay by cash, personal check (with proper identification), or accepted credit cards. In order to avoid misunderstandings, please let us know immediately if these terms are not satisfactory.

In the event payment is not made at the time of service, it is our policy to apply a service charge to accounts with a balance over 30 days old. A service fee of \$3.00 and 1.5% of the outstanding balance will be charged to your account monthly if not paid in full.

All returned checks will incur a charge of \$25.00 and may be referred to the District Attorney for collection.

### NAMES OF INDIVIDUALS AUTHORIZED TO PICK UP PATIENT FROM VRCC:

Name: \_\_\_\_\_ Name(s): \_\_\_\_\_

I understand that I (the owner or agent) am financially responsible to the applicable VRCC practice(s) for all charges relating to this patient. I have read and agree to the treatment authorization. I have also read and accept the financial obligations.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## Animal Medical Specialists— Medical History

To aid us in reaching an accurate diagnosis, a complete background on your pet is essential. Please fill out all pages of the following questionnaire to the best of your ability.

Pet's Name:	
How long have you owned your pet?	
Where was your pet obtained?	
Is your pet kept primarily out-of-doors or in the house?	
Is your pet allowed to roam free?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has your pet been boarded, hospitalized, or at the animal shelter recently?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, where?	
Are there any other animals in your household?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what kind(s)?	
What does your pet eat?	
Approximately how much and how often does your pet eat?	
Is your pet ever fed tablescraps?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what kinds of food?	
Prior to this illness, has your pet been treated for any major medical problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what type and when?	
If your pet is neutered/spayed, what was his/her age when this surgery was performed?	
Has your pet undergone any other surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what type of surgery and when?	
If your pet is female and not spayed:	
When was her last heat cycle?	
Has she had any litters?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, when?	
Is your pet now taking medication to prevent heartworm disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has your pet traveled out of Colorado?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, where and when?	
Has your pet's appetite increased or decreased recently?	<input type="checkbox"/> Yes <input type="checkbox"/> No



**Animal Medical Specialists— Medical History Continued**

<b>Vaccination History</b> — When was your pet last vaccinated against:	
<i>Dog:</i> Distemper/Hepatitis/Leptospirosis?	
Rabies?	
Parvovirus?	
<i>Cat:</i> Panleukopenia (feline distemper)?	
Rhinotracheitis/Calicivirus (respiratory viruses)?	
Has your pet lost stamina recently?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is your pet drinking more water than usual?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is your pet urinating more frequently than usual?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is your pet straining to urinate?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is there any blood or discoloration of your pet's urine?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has your pet been vomiting frequently?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have there been recent changes in the frequency, amount or color of your pet's bowel movements?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is your pet straining to defecate?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has your pet been scratching/itching?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has your pet had any seizures or convulsions?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has your pet shown any changes in attitude or behavior?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has your pet's walk changed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you noticed any swelling or masses?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, where?	
If your pet is female, has there been any abnormal vaginal discharge?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has your pet had unusual/unexpected reactions to medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has your pet had any discharge from the eyes or nose?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has your pet been sneezing excessively?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has your pet been coughing or showing difficulty breathing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
What is your primary concern about your pet?	

**Thank you for completing this form. A thorough medical history is essential if proper therapy is to be administered to your pet.**

