

Intake Form

Patient Label

- Does your pet have insurance? Yes NoIf **yes**, what insurance? _____

- Is the information on the label to the left up to date?

 Yes No, If **no** please write in your new information down below.

Client First and last name: _____

Address: _____ City: _____ State: _____

Zip: _____ Email Address: _____

Visit Information:

1. Complaints, symptoms, or behavioral concerns: _____

2. How long have you had your pet? _____

3. Where did you obtain your pet from?(ex: pet store, friend, etc.) _____

4. Is your pet wild caught or an aviary bird? _____

5. Are there any other birds in the home? Yes NoIf **yes**, please elaborate: _____6. Are there any other animals at home? Yes NoIf **yes**, please elaborate: _____7. Has your pet had any previous medical history or testing? Yes NoIf **yes**, please elaborate: _____

8. Where does your bird live? Where is it located within the home? _____

9. Does your bird have access to direct unfiltered sunlight daily? Yes No

10. Please specify if your bird is free-flight or trimmed: _____

11. Is your bird eating well? Yes NoIf **no**, please elaborate: _____12. **Diet information:** What is their diet type and amount they eat? _____13. Does your bird take any vitamin or mineral supplements? Yes NoIf **yes**, please list brand(s) and amount they take: _____14. **Is your bird currently taking any medications?** Yes NoIf **yes**, please list the names and dosages of the medications: _____

15. How often is your bird defecating and are there any abnormalities? _____

16. Is your bird coughing or sneezing? Yes NoIf **yes**, please elaborate: _____17. Is your pet exposed to any toxins? (teflon or non stick pans, cigarette or other smoke, aerosol sprays, household plants, metal toys, lead exposure in paint or toys?) Yes NoIf **yes**, please elaborate: _____

Rabbit

Date: _____

Patient Label

Intake Form

- Does your pet have a microchip? Yes No

- Does your pet have insurance? Yes No

If **yes**, what insurance? _____

- Is the information on the label to the left up to date?

Yes **No**, If **no** please write in your new information down below.

Client First and last name: _____

Address: _____ City: _____ State: _____

Zip: _____ Email Address: _____

Visit Information:

1. Has your pet been vaccinated for the rabbit hemorrhagic disease? **Yes** **No**

2. Complaints/Symptoms: _____

3. Is your pet on any medication and or supplements? **Yes** **No**

If yes, please list prescription(s) & dosages: _____

4. Does your pet have excessive urination or thirst? **Yes** **No**

5. How long have you had your pet? _____

6. Where did you obtain your pet from?(ex: pet store, wild caught, etc.) _____

7. Do you own other rabbits? **Yes** **No**

8. Has your rabbit been exposed to other rabbits or pets? **Yes** **No**

9. How is your pet housed? (ex: indoor, outdoor, free roam, etc.) _____

10. What is your pet's diet? Please list type of hay, pellets, as well as how much is given. If you pet given veggies please list which kinds and any treats. _____

11. Please list any known medical conditions and previous vet hospital(s) if any. _____

12. While your pet is here, can they have treats to make their visit more pleasant?

(ex:celery) **Yes** **No**

STAFF ONLY SECTION BELOW:

Weight: _____ Temp: _____ Pulse: _____ Respiration: _____

Additional Notes:

Reptile

Date: _____

Intake Form

Patient Label

- Does your pet have insurance? Yes No

If yes, what insurance? _____

- Is the information on the label to the left up to date?

Yes No, If no please write in your new information down below.

Client First and last name: _____

Address: _____ City: _____ State: _____

Zip: _____ Email Address: _____

Visit Information:

1. Complaints/Symptoms: _____

2. Does you pet have any nasal discharge or sneezing? Yes No

If yes, elaborate: _____

3. Is your pets stool production and quality normal? Yes No

If no, please elaborate: _____

4. Is your pet urinating normally? Yes No

If no, please elaborate: _____

5. How long have you had your pet? _____

6. Where did you obtain your pet from?(ex: pet store, wild caught, etc.) _____

7. Do you own other reptiles? Yes No

8. Has your reptile been exposed to other reptiles or pets? Yes No

9. How is your pet housed? (Size, shape, location in household, etc.) _____

10. What substrate is used in housing? _____

11. What type of lighting is used? (ex: UV, red light, heating lamps, UVB/UVA, mercury vapor, etc) _____

12. What type of heat do you use? (type and temperature) _____

13. What are the temperature and humidity readings in the cage? _____

14. Diet information including supplements or dust: (How frequent feeding is and all types of food being offered) _____

STAFF ONLY SECTION BELOW:

Weight: _____

Additional Notes:

Rodent

Date: _____

Patient Label

Intake Form

- Does your pet have a microchip? **Yes** **No**
- Does your pet have insurance? **Yes** **No**
If **yes**, what insurance? _____
- Is the information on the label to the left up to date?
 Yes **No**, If **no** please write in your new information down below.

Client First and last name: _____

Address: _____ City: _____ State: _____

Zip: _____ Email Address: _____

Visit Information:

1. Complaints/Symptoms: _____

2. Is your pet on any medication and or supplements? **Yes** **No**
If yes, please list prescription(s) & dosages: _____

3. If your pet is a guinea pig, are they taking a vitamin C supplement? **Yes** **No**
If yes, can you please list which brand/form of vitamin C supplement they are taking?

4. Does your pet have any excessive urination or excessive water intake? **Yes** **No**

5. How long have you had your pet? _____

6. Does your pet have any coughing, sneezing, or diarrhea? **Yes** **No**

7. Where did you obtain your pet from?(ex: pet store, wild caught, etc.) _____

8. Do you own other rodents? **Yes** **No**

9. Has your rodent been exposed to other rodents or pets? **Yes** **No**

10. How is your pet housed? (ex: indoor, outdoor, free roam, etc.) _____

11. What is your pet's diet? Please list type of pellets, treats, or other items being offered

12. Please list any known medical conditions and previous vet hospital(s) if any. _____

13. While your pet is here, can they have treats to make their visit more pleasant?
(ex:grains) **Yes** **No**

STAFF ONLY SECTION BELOW:

Weight: _____

Additional Notes: