

Client Registration Form - Canine

Owner/Trainer

Dog

Full Name		Full Name	
Address		Age	
Postcode		Breed	
Telephone		Sex	
Mobile		VET Name	
Email Address		Clinic Address	
Dog Owned Since		Postcode	
Dog Worked By	<input type="checkbox"/> Yourself <input type="checkbox"/> Another	Telephone	
Signature*		Email Address	
Date			

*This signature indicates that you agree for your dog to receive treatment, and that all necessary veterinary consent has been obtained.

Confidential Health Questionnaire

Last VET Visit	
Current Medical Conditions	
Current Medication	
Previous Treatment/Therapies	
Exercise Regime	
Type of Work/Competition	
Feed and Supplements	
Has your dog ever suffered from the following conditions:	
<input type="checkbox"/> Allergies	<input type="checkbox"/> Respiratory <input type="checkbox"/> Arthritis
<input type="checkbox"/> Gastrointestinal	<input type="checkbox"/> Eczema/Skin <input type="checkbox"/> Lameness
If Yes, or Other, please explain:	
Previous Injury/Trauma	
<input type="checkbox"/> Muscular	<input type="checkbox"/> Tendon <input type="checkbox"/> Ligament
<input type="checkbox"/> Back/Neck/Pelvis	<input type="checkbox"/> Fractures <input type="checkbox"/> Other
If Yes, please explain:	
Does the current complaint affect exercising your dog? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you consulted your VET regarding the current problem?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> VET advised
Please describe the current issue/reason for assessment:	

Office Use ONLY: VET Contacted:

Via:

Approval of Rx:

Yes

No