Holistic Pet Vet Clinic

Quality Integrative Medicine with an Emphasis on Naturopathic Care

Pet Information

Name: _____ Birth date/approximate age: _____

Species: ❑ Dog ❑ Cat

Sex: ❑ Female ❑ Male

Spayed/neutered? ❑ No ❑ Yes, at age: _____

Breed: _____ Color: _____

Vaccinations: (date/type): _____

Has your pet had any adverse reactions to vaccines? If so, please describe: _____

_____

Diet: _____

Current medications and dosage: _____

Primary reason for visit: _____

Please check any of the following that you have noticed in the past 30 days:

Appetite loss ___	Behavioral changes ___	Coughing ___	Limping ___
Diarrhea ___	Breathing problems ___	Scratching ___	Sneezing ___
Vomiting ___	Bleeding gums ___	Scooting ___	Fleas ___
Urinary issues ___	Change in thirst ___	Eye problems ___	

Other: _____

If you checked any of the above, please specify approximate date and duration of occurrence(s).

_____

_____

_____

Authorization

I hereby authorize the veterinarian to examine, prescribe for, and treat the animal described above. I certify that this is, indeed, my animal, or that I have been authorized by its rightful guardian to seek medical services. I assume all financial responsibility for services provided and charges incurred in the care of this animal. I understand that all charges are to be paid at the time services are rendered unless a prior arrangement has been established.

_____ _____

Guardian or Responsible Party Date

_____ _____

Holistic Pet Vet Clinic Witness Date

11505 SW Pacific Highway, Suite D, Tigard, Oregon 97223 *Phone: 503-293-6666, Fax 503-293-1721* *holisticpetvet@holisticpetvetclinic.com*