



Patient's name:

Household members

Adults (names):

Children (names/ages):

Dogs (name/age/breed):

Cats (name/age):

Other pets:

Activities of Daily Living

Does your pet have difficulties with any of the following activities?

Climbing stairs

Urinating or defecating

Eating from food dish

Walking on smooth surfaces

Walking on carpet or grass

Getting in or out of bed

Getting in or out of the car

Getting on or off furniture

If yes, please describe below:

Does your pet climb stairs?

How does your pet get in and out of the car?

Jumping

Ramp

Lifting

Steps

How does your pet behave in the car?

Sits or lays quietly

Walks around

Jumps

Barks

Have you noticed any recent change in daily routines?

Type of flooring:

Type of pet bed:

Home alterations previously made for your pet (ie: stair gates, throw rugs, ramps):

Patient's lifestyle

___ Non-mobile

___ Couch potato

___ Active house pet

___ Competitive athlete

Which sport _____

___ Working dog

Type of work _____

___ Running partner

Miles per run _____

Patient information

Breed:

Age:

Gender: Male Male/neutered

Female Female/spayed

Allergies/drug reactions:

How did you hear about us?

Were you referred by a veterinarian?

Clinic Name:

Current activity level:

Type & length of daily exercise (length in miles or minutes): _____

On leash or off leash?

Daily exercise is on grass, cement, dirt or grass?

Number of days per week your pet exercises:

Has there been a recent change in activity?

Commands/tricks already trained:
sit stand down stay crawl bow back
roll-over beg wave other: _____

Behavior on leash:
Pulls Wild Calm Doesn't pull

Unsupervised time is spent in:
Crate
Loose in house (flooring _____)
Yard
Room confinement
(flooring _____)

Diet

Current food:

Number of meals per day:

Volume of food per meal:

and type of treats given:

Human food given? yes no

Any recent weight loss? yes no

Previous medical history

Dietary supplements:

Medications:

Previous illness or injuries:

Previous treatments or surgeries:

Recent tests:

Blood or urine tests:

X-rays, OFA/Penn Hip:

MRI or CAT Scan:

Current Medical Conditions:

Infections	Yes	No
Skin wounds	Yes	No
Breathing problems	Yes	No
Heart problems	Yes	No
Pace maker	Yes	No
Seizures/epilepsy	Yes	No
Cancer	Yes	No
Skin lumps	Yes	No
Pregnant	Yes	No
Bone plates/pins	Yes	No
Recent cortisone injection	Yes	No
Recent bleeding	Yes	No
Vomiting or diarrhea	Yes	No

Describe the injury:

When did it start? _____

Progression: Better Worse Unchanged

Current pain level 1-5 (0-no pain, 3-significant pain, 5-excruciating pain):

Bladder control: normal incontinent

Bowel control: normal incontinent

What makes it worse? Running, jumping, stairs, exercise, cold weather,

Other: _____

What makes it better? Exercise, rest, warmth, supplements, medicines,

Other: _____

What are your goals for rehab?

Any other information we should know?

