Companion Animal Hospital
of middletown

We are honored to have the opportunity to care for your companion. To ensure your companion gets the best care we can offer, please fill out this form completely.

Client Information

Date: _____/_____/_____

Owner's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Birthdate: _____/_____/_____ Phone: (____)_____ Email: _____

Employer: _____ Work Phone: (____)_____

Emergency Contact Name: _____ Phone: (____) _____

Number of Pets (please specify type):_____

Companion Health History

Companion's Name: _____ Age: _____

Type: _____ Breed: _____ Color: _____

Sex: M☐ F☐ Neutered/Spayed: Y☐ N☐ Date: _____/_____/_____

Current medications your companion is taking: _____

_____

Vaccination History:

☐ Distemper Date: ____/____/____ ☐ Parvovirus Date: ____/____/____ ☐ Rabies Date:____/____/____

Primary reason for visit: _____

Symptoms your pet is demonstrating:

☐ Appetite Loss	☐ Diarrhea	☐ Loss of Balance	☐ Thirst
☐ Behavioral Changes	☐ Eye Disorders	☐ Scooting	☐ Urination Increase
☐ Breathing Problems	☐ Gagging	☐ Scratching	☐ Vomiting
☐ Coughing	☐ Gums Bleeding	☐ Shaking Head	☐ Weakness
☐ Depression	☐ Limping	☐ Sneezing	☐ Other: _____

Prior Surgeries: _____

Prior Illnesses: _____

Authorization

I hereby authorize the veterinarian to examine, prescribe for, or treat the above described companion.
I assume responsibility for all charges incurred in the care of the animal. I also undersand that all professional fees are dus at the time services are rendered.

Signature of the responsible pary: _____ Date: _____/_____/_____

The information on this form is strictly confidential and is to be used only by this practice to provide care and treatment for your pet.