CLIENT INFORMATION SHEET

www.kinder4rescue.org

Send Records and Xrays to⟶ **xrays@kinder4rescue.org**

Client Information

Microchip#_____ ☐ Need Microchip

Owner's name: _____ Driver's License: _____ DOB_____

CONTROLLED SUBSTANCE REQUIREMENT

Check box for which number we can reach you at today:

Phone: ☐ (Home): _____ ☐ (Cell):_____ ☐ (Work): _____

Email:_____

Address: _____ Apt #: _____

City: _____ State:_____ Zip Code:_____

Spouse/Other: _____ Phone (Cell): _____

In case of Emergency, call: _____ Alt: (_____) _____

Method of Payment: ☐ Cash ☐ Credit Card ☐ Scratchpay.com ☐ Venmo ☐ Other: _____

How did you hear about us? _____

Pet Information

Pet's Name_____ Species: Canine/Feline Breed: _____

Color: _____ Age: _____

Female Spayed/Castrada - Yes ☐ No ☐ Male Neutered/Castrado - Yes ☐ No ☐

How many other pets do you have at your house?_____ Female Spayed/Castrada - Yes ☐ No ☐ Species: Cat / Dog

Male Neutered/Castrado - Yes ☐ No ☐ Species: Cat / Dog

Previous/Current Vet: _____

Does your company have a matching donation program?

☐ **Yes** ☐ **No**

I am the owner (or authorized agent for the owner) of this pet and over 18 years of age. The information given above is correct. I understand every effort will be made to achieve a successful outcome and to provide for all possible safety Clinic Care and handling. I hereby authorize this clinic to receive, prescribed for, and treat the pets(s) listed above. Furthermore, I agree to pay fees for all services rendered at the time the pet is discharged from the clinic. I understand I am responsible for payment and agree to pay the reasonable costs of collection, attorney fees, and court costs in the event that collection efforts become necessary. I agree that the venue of this action will be in the county where the clinic is located. I also authorize *Kinder4Rescue Low Cost Vet Clinic* to release or transfer my pet's medical records to another Veterinary and/or Boarding Facility. Please notify Kinder4Rescue if Payment Assistance is needed prior to services. A list of foundations that assist in medical care can be provided for pre-approval.

Signature: _____ Date: _____

Patient History

Date: _____

Pet Owner's Name: _____

Pet's Name: _____

☐ Dog ☐ Cat ☐ Other _____ **Fixed / Castrado/a ☐ Yes ☐ No**

DATE OF INJURY_____ How did the injury occur? _____

HAS YOUR PET…

1. Annual vaccinations within the last year?	☐ Yes	☐ No	☐ Unsure
2. Rabies vaccination current?	☐ Yes	☐ No	☐ Unsure
3. Any recent surgery or dentistry?	☐ Yes	☐ No	☐ Unsure
4. Any illness or injury?	☐ Yes	☐ No	☐ Unsure
5. Medication or a current medical problem?	☐ Yes	☐ No	☐ Unsure

If YES, _____

6. Any recent physical examination within the last year?	☐ Yes	☐ No	☐ Unsure
7. Any recent bloodwork, x-rays, ECG, other? (Circle)	☐ Yes	☐ No	☐ Unsure
8. Exposure to any animal with an unknown illness?	☐ Yes	☐ No	☐ Unsure
9. A recent pregnancy or heat period? (Circle)	☐ Yes	☐ No	☐ Unsure

10. When was the last time your pet ate? Date: _____ Time: _____

HAVE YOU NOTICED ANY…

1. Coughing, sneezing, shortness of breath, or tiring easily?	☐ Yes	☐ No	☐ Unsure
2. Change in appetite or eating habits/weight loss? (Circle)	☐ Yes	☐ No	☐ Unsure
3. Recent vomiting?	☐ Yes	☐ No	☐ Unsure

If YES, when did it start? _____ Color of vomit: _____-_____

4. Recent diarrhea?	☐ Yes	☐ No	☐ Unsure
If YES, when did it start? _____ Blood in stool:	☐ Yes	☐ No	☐ Unsure
5. Change in thirst or urination? (Circle)	☐ Yes	☐ No	☐ Unsure
6. Blood in urine, or other discharge? (Circle)	☐ Yes	☐ No	☐ Unsure
7. Unusual attitude, fainting, or seizure? (Circle)	☐ Yes	☐ No	☐ Unsure
8. Swelling, limping, or pain in moving? (Circle)	☐ Yes	☐ No	☐ Unsure

If YES, when did it start? _____

How closely is your pet observed? _____

Other Info: _____

_____

TO BE COMPLETED BY CLINIC ONLY

Orders:

1. _____

2. _____

3. _____

4. _____

5._____

TO BE COMPLETED BY CLINIC ONLY

Notes:

_____

_____

_____

_____

_____

Physical Exam **Date:** _____

Weight _____ Attitude _____ BCS ___ / 9

	Normal	Abnormal	Remarks
Hydration	☐	☐	
Eyes	☐	☐	
Ears	☐	☐	
Nose	☐	☐	
Mouth	☐	☐	
PLNs	☐	☐	
Skin	☐	☐	
Respiratory	☐	☐	
Cardiovascular	☐	☐	
Abdomen	☐	☐	
Neuro	☐	☐	
Musculoskeletal	☐	☐	
Left front	☐	☐	
Right front	☐	☐	
Left hind	☐	☐	
Right hind	☐	☐	

TO BE COMPLETED BY CLINIC ONLY

Doctor's Notes: _____

Assessment: _____

Bloodwork: _____

_____

XRays: _____

_____

Recommendation/Refer to:_____

Surgery: _____

Patient Information – CLIENTS TO COMPLETE BELOW

Pet's Name: _____

Owners Name: _____

Breed: _____ Color: _____

Age: _____ Sex: M / F Spayed/Neutered: Y / N

Kinder4Rescue
Low Cost Pet Clinic & Adoption Center
4926 Vineland Ave, North Hollywood, CA 91601
Office: (818) 505-0006

Financial **BW** ☐125 ☐150 ☐89

XR ☐150 ☐75

☐**Deposit** ☐**Rebate** -

Total $