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: ____________________

Species: ☐Dog ☐Cat ☐Other ____________

Sex: ☐***Intact*** Male ☐***Neutered*** Male

☐***Intact*** Female ☐***Spayed*** Female

Reason for visit: ____________________

____

Date of Injury: ____________________

How did the injury occur? ____________________

____

____

Do you have recent records? ☐Yes ☐No **Sent:** ☐Yes ☐No

Email: xrays@kinder4rescue.org Fax: 1 (818)-505-0026

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: ____________

Drinking more or excessive water intake?	☐ Yes	☐ No	☐ Unsure

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. Blood in urine, or other discharge? (Circle)	☐ Yes	☐ No	☐ Unsure
6. Unusual attitude, fainting, or seizure? (Circle)	☐ Yes	☐ No	☐ Unsure
7. Swelling, limping, or pain in moving? (Circle)	☐ Yes	☐ No	☐ Unsure

8. Is your pet unable to urinate? ☐ **Yes**- spot peeing. ☐ **No**- *Not* urinating. Color of urine: ____________

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

FINANCIAL

☐Prev **BW** date __________ **BW** ☐125 ☐150 ☐89	
Voucher: ☐ Done ☐ Received **XR** ☐150 ☐75	
☐Pain Inj.|Meds ☐Overnight	/
☐**Deposit** ☐**Rebate**	
Balance: $ ________ ☐**PD** **Total:**	$
☐PB ☐Credit|Debit (2.6%) ☐Venmo ☐ScratchPay	