

Owner Name : _____
 Gender : (Check one) M MN F FS

Pet Name : _____
 Age/DOB : _____

ISSUE (Circle what applies)	NO	MILD	MODERATE	SEVERE	When did problem begin?
Weight gain or loss					
Appetite increase or decrease					
Vomiting or diarrhea					
Constipation or straining					
Increased thirst					
Increased urination					
Lumps or tumors					
Skin problems or itching					
Bad breath /difficulty chewing					
Decreased awareness, confused					
House soiling/spraying					
Decreased interaction w/ others					
Chewing, licking, repetitive behavior, pacing					
Increased irritability/aggression					
Increased fear/anxiety					
Decreased tolerance of touch					
Decreased hearing					
Decreased grooming or self-care					
Muscle tremors/shaking					
Weakness/ incoordination					
Difficulty moving/stiffness					
Decreased activity, sleeping more					

Excessive vocalization - Day or Night					
Waking owners at night					

Other Problems or concerns:

Medications:

Existing/On-going medical problems:

Budget: _____

Date/Time: _____