Pet Information

Pet Name:_____ Vaccinated: YES ~ NO Markings/Breed:_____

Age:_____ DOB_____ Microchip?_____

Temperament/Personality :

Energy level: High____ Balanced_____ Mellow_____

Has your dog/cat ever bitten a person or another animal?

_____

_____

Favorite toy, activity, and cuddle/sleep spots:

_____

_____

List of Commands:

_____

_____

Any Fears, Phobias or History of Biting

_____

_____

Morning Schedule	Afternoon Schedule	Night Schedule
Prefered visit time: Medication time: Meal time: Activity(walk,play etc):	Prefered visit time: Medication time: Meal time: Activity(walk,play etc):	Prefered visit time: Medication time: Meal time: Activity(walk,play etc):

Feeding Instructions

( )Feed apart from other pets/supervise ( ) Dispose of uneaten food ( )Remove food after ____ Min

❑ Dry ❑ Wet ❑ Mixed	❑ AM ❑ NOON ❑ PM	Amount: _____ Brand _____ Procedure and Location: _____
Treats	❑ AM ❑ NOON ❑ PM	Amount _____ Brand _____ Frequency _____
Water	❑ Tap ❑ Bottled ❑ Filtered	Locations: _____

Emergency and Medical Care

Veterinarian Clinic	Veterinarian	Phone Number ( ) -
Medication (supplement) name	Directions	Notes
Medication (supplement) name	Directions	Notes
Allergies:	Food Restrictions:	Ongoing illnesses/injuries/health concerns:

*If you feel there is more information needed to better provide for your pet, please write on the back of this paper or email a separate document with the additional information.