

# Patient Information Form

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Owner's Name \_\_\_\_\_

Patient Name \_\_\_\_\_

**Diet History**

Current Diet/ Brand \_\_\_\_\_

Amount fed per meal \_\_\_\_\_ Meals/day (or free choice) \_\_\_\_\_

Do you have concerns about your pet's weight? Yes No

Is your pet overweight or underweight? \_\_\_\_\_

Does your pet get treats? Yes No If yes, what type & how many? \_\_\_\_\_

Do you have other pets? Yes No If yes, list names, species, age and breeds below.

Who feeds pets? \_\_\_\_\_

**Activity Level**

How much activity does your dog get per day?

Less than 15 min a day 15-30 min 30-60 min More than 60 min a day

What types of activity are typical for your pet? (Check all that apply)

Walking Jogging Frisbee Agility Fly Ball Swimming Running in yard  
 Playing with Toys Play with other dogs/day care Other :

Have you noticed recent changes in behavior or activity level? If yes, please describe fully:

**At Home**

How many hours is someone home with your pet on an average work day? \_\_\_\_\_

Where does your pet rest when no one is home? \_\_\_\_\_

Are you interested in exercise and therapies that you may be able to perform at home?  
 Yes No

Please flip the page and complete the remaining questions, then sign and date at the bottom.



