



SUNSHINE PET CLINIC CLIENT / PATIENT INTAKE FORM

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Please ✓ New Client Existing Client *is this a:* Sick / Injured visit Annual Exam / Vaccines

CLIENT INFORMATION

OWNER(S): _____ DATE OF VISIT: _____
FIRST / LAST

ADDRESS: _____ CITY _____ STATE _____ ZIP _____
NUMBER & STREET

BEST PHONE CONTACT #: _____ ALTERNATE PHONE #: _____

PRIMARY E-MAIL ADDRESS: _____

CO-OWNER OF PET/NAME OF AUTHORIZED AGENT: _____

CONTACT INFO FOR CO-OWNER/AUTHORIZED AGENT: _____
PHONE # E-MAIL ADDRESS (IF APPLICABLE)

PREFERRED METHOD OF CONTACT: Phone call E-mail Other _____

GENERAL PATIENT INFORMATION

PET'S NAME: _____

SPECIES (check one): Dog Cat Other (please specify): _____

BREED: _____ COLOR(S): _____

SEX: Male Female SPAYED / NEUTERED: Yes No

DATE OF BIRTH (or approximate age if DOB unknown): _____

PREVIOUS VETERINARIAN (if not applicable skip this section)

NAME OF VETERINARY PRACTICE: _____

CITY & STATE: _____

PHONE#: _____ MAY WE REQUEST YOUR PET'S RECORDS? Yes No

GENERAL PATIENT HEALTH INFORMATION

WHAT DO YOU CURRENTLY FEED YOUR PET? (Name/type of food - eg. Purina One dry kibble mixed w/ canned Purina Smart Blend)

IS YOUR PET CURRENTLY ON FLEA / TICK / HEARTWORM PREVENTION?

If yes, please check the preventatives your pet is on: Bravecto Credelio Revolution NexGard Other

Continued on reverse side → → →

Client ID Number _____

GENERAL PATIENT HEALTH INFORMATION - continued

DO YOU ADD ANY SUPPLEMENT TO YOUR PET'S DIET? (Fish oil, Pet Tabs, probiotics, CBD oil, etc.)

Yes

No

Please list the names of any supplements given to your pet:

DOES YOUR PET SPEND MOST OF HIS/HER TIME:

Indoors

Outdoors

ARE THERE ANY BEHAVIORAL ISSUES YOU WOULD LIKE TO DISCUSS TODAY?

Yes

No

PLEASE LIST ANY BEHAVIORAL PROBLEMS (voiding outside litter box; excessive barking; biting or aggression towards other people/pets; Socialization problems, etc.)

DOES YOUR PET HAVE ANY ALLERGIES:

Yes

No

If yes, please describe below:

DOES YOUR PET CURRENTLY HAVE ANY KNOWN CHRONIC CONDITIONS OR ABNORMALITIES?

Yes

No

If so, please list here: (Hip dysplasia, cancer, diabetes, thyroid condition, Cushing's Disease, etc.)

IS YOUR PET MICROCHIPPED?

Yes

No

If no, would you like to have your pet microchipped today?

Yes

No

PLEASE LIST ANY MEDICATIONS YOUR PET IS CURRENTLY TAKING:

PLEASE LIST ANY OTHER CONCERN YOU MAY HAVE?

Client ID Number _____