

For K-9s & Felines, LLC

45 Southwick Road, Westfield, MA ~ 413.572.0055

Client Intake Form

CLIENT INFORMATION:

First Name: _____ Last Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Ext.: _____
Cell Phone: _____ SMS/Text Message Reminders? Yes / No
Email: _____ Preferred Contact Method: Phone, E-mail, Text

Alternate Contact: _____ Alternate Phone: _____
Emergency Contact: _____ Emergency Phone: _____

Referred by: _____
Prior Groomer: _____ Reason for leaving: _____

PET #1 INFORMATION:

Pet Name: _____ Breed: _____
Sex: _____ Spayed/Neutered? Yes / No
Color: _____ Weight (lbs): _____
Date of Birth *: _____
* If unknown, use date on vet records. Registration # _____ (optional)
Purchased from: _____ Microchip # _____ (optional)
Veterinarian: _____
Name Street, City, Zip

MEDICAL INFORMATION:

VACCINATIONS:

	Vaccinated	Expires
Rabies (Required)	/ /	/ /
Dog (C) DHPP	/ /	/ /
Cat (C) FVRCP	/ /	/ /

(C) = Core Vaccine (Will accept titers.)

***** Proof of immunizations required. *****

List any behavior issues (biting, handling, etc.)?

MEDICAL INFORMATION (Circle any of the following)

Arthritis? Thyroid / Cushings / Addisons?
Blind / Sight Impaired? Heart Murmur / Disease?
Deaf / Hearing Impaired? Diabetes?
Luxating Patellas? Seizures?
Allergies? Dental Issues / Disease?
Collapsed Trachea?
Other? _____

List any surgeries: _____

Additional pets on reverse side.

PET #2 INFORMATION:

Pet Name: _____

Sex: _____

Color: _____

Date of Birth *: _____

** If unknown, use date on vet records.*

Purchased from: _____

Veterinarian: _____

Name

Breed: _____

Spayed/Neutered? Yes / No

Weight (lbs): _____

Registration # _____ (optional)

Microchip # _____ (optional)

Street, City, Zip

MEDICAL INFORMATION:

VACCINATIONS:

	Vaccinated	Expires
Rabies (Required)	/ /	/ /
Dog (C) DHPP	/ /	/ /
Cat (C) FVRCP	/ /	/ /

(C) = Core Vaccine (Will accept titers.)

***** Proof of immunizations required. *****

List any behavior issues (biting, handling, etc.)?

MEDICAL INFORMATION (Circle any of the following)

Arthritis? Thyroid / Cushings / Addison's?

Blind / Sight Impaired? Heart Murmur / Disease?

Deaf / Hearing Impaired? Diabetes?

Luxating Patellas? Seizures?

Allergies? Dental Issues / Disease?

Collapsed Trachea?

Other? _____

List any surgeries: _____

PET #3 INFORMATION:

Pet Name: _____

Sex: _____

Color: _____

Date of Birth *: _____

** If unknown, use date on vet records.*

Purchased from: _____

Veterinarian: _____

Name

Breed: _____

Spayed/Neutered? Yes / No

Weight (lbs): _____

Registration # _____ (optional)

Microchip # _____ (optional)

Street, City, Zip

MEDICAL INFORMATION:

VACCINATIONS:

	Vaccinated	Expires
Rabies (Required)	/ /	/ /
Dog (C) DHPP	/ /	/ /
Cat (C) FVRCP	/ /	/ /

(C) = Core Vaccine (Will accept titers.)

***** Proof of immunizations required. *****

List any behavior issues (biting, handling, etc.)?

MEDICAL INFORMATION (Circle any of the following)

Arthritis? Thyroid / Cushings / Addison's?

Blind / Sight Impaired? Heart Murmur / Disease?

Deaf / Hearing Impaired? Diabetes?

Luxating Patellas? Seizures?

Allergies? Dental Issues / Disease?

Collapsed Trachea?

Other? _____

List any surgeries: _____
