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: _____ 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: _____

PET #3 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: _____