



To Continental Animal Wellness Center

Thank you for giving us the opportunity to care for your pet. We'll be happy to answer any questions you have about your pet's health. To insure the best care possible, please take the time to fill in this form completely. Thank you!

REGISTRATION

Date: _____
 S.S. # _____
 Owner: _____
 Address: _____ Zip Code: _____
 Spouse: _____
 Home phone # _____ Cell Phone # _____ Work Phone # _____
 Email (for specials) _____
 Emergency contact & Phone # _____
 How did you hear about us? _____
 Number of pets: Dogs _____ Cats _____ Other (Specify) _____
 Reason for visit? _____ Are you interested in learning about acupuncture? _____

PET HEALTH HISTORY

Name of pet _____ Dog ___ Cat ___ Other ___
 Breed _____ Color _____ Date of Birth _____
 Male _____ Neutered _____ Female _____ Spayed _____
 Vaccination History (Date and type of last vaccination) _____

Please check any symptoms or problems that you have noticed about your pet:

<input type="checkbox"/> Behavioral Problems	<input type="checkbox"/> Lack of Appetite	<input type="checkbox"/> Sneezing
<input type="checkbox"/> Bleeding Gums	<input type="checkbox"/> Limping	<input type="checkbox"/> Thirst &/or Urinating increased
<input type="checkbox"/> Breathing Problems	<input type="checkbox"/> Loss of Balance	<input type="checkbox"/> Vomiting
<input type="checkbox"/> Coughing	<input type="checkbox"/> Scooting	<input type="checkbox"/> Weakness
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Scratching	<input type="checkbox"/> Other _____
<input type="checkbox"/> Eye Bulging or Bloodshot	<input type="checkbox"/> Seems Depressed	_____
<input type="checkbox"/> Gagging	<input type="checkbox"/> Shaking Head	_____

Pet's current medications _____
 Describe your pet's diet _____

AUTHORIZATION

I hereby authorize the veterinarian to examine, prescribe for, or treat the above described pet. I assume responsibility for all charges incurred in the care of this animal. I also understand that these charges will be paid at the time of release and that a deposit may be required for surgical treatment.

Signature of Owner _____ Date _____