



Utah Pet Rehab & Acupuncture Center, LLC

Patient Information and History

Date: _____ Primary Vet: _____

Referred By: _____

Owner(s) Name: _____

Address: _____

Email: _____

Main Phone: _____ Other: _____

Patient Name: _____ Species: Canine Feline

Breed: _____ Color: _____

Gender (Circle): Male/Castrated Female/Spayed

Date of Birth: _____ DATE OF SURGERY (If applicable): _____

Reason for today's visit and history of present illness: _____

Past medical/surgical history: _____

Allergies: _____

Diet: _____

May I have treats?: _____

Supplements/Medication: _____

Treatment since injury/surgery: _____

Current and previous activity level: _____

Expectations and goals for your pet: _____
