

NOTE: download a copy of this pdf and SAVE your information to the file before attaching and emailing back to us at okobojivet@gmail.com



Client Contact Information

Thank you for choosing Okoboji Veterinary Hospital for your furry family members! We hope you feel like a part of our family here!

How did you hear about us?

Google ____ Facebook/Social media ____ Hospital sign ____

Personal recommendation ____ (Whom can we thank? _____)

Other: _____

*Please check all of your contact details on this form carefully (especially email and cell phone number -- it is the primary way your reminders and appointment confirmations will be sent)! *Indicates a required field*

Mrs. ____ Mr. ____ Ms. ____ Dr. ____

*First name: _____ *Last name: _____

*Address: _____

*City: _____ *State: _____ *ZIP: _____

Home phone: (____) _____ *Cell: (____) _____

*Email: _____

If you would like to add a spouse and/or other authorized contacts for your pets, please enter their information here (if they have the same address as you, just type "same" in the address line):

Mrs. ____ Mr. ____ Ms. ____ Dr. ____ Relationship: _____

First name: _____ Last name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Home phone: (____) _____ Cell: (____) _____

Email: _____

***FOOD ALLERGIES:** Please note that we often use food as a positive reinforcement or distraction tool to help pets acclimate to examination and treatment procedures (peanut butter, spray cheese, kibble, canned food). If you, a family member, or your pet have a food allergy please let us know! If there are any concerns about a potential issue, please list them here:*

Allergens for family: _____

Allergens for pet(s): _____

Please list your pet's information below to ensure correct spellings and birthdays! If you have multiple pets you wish to add, please list their information on this sheet as well! If you need more space, don't worry – just bring their information with you and we can get it all in our system!

Name: _____

Species: __Dog __ Cat Breed: _____

Gender: __ Female __ Spayed Female __ Male __ Neutered Male

Age/birthday (if known): _____

Name: _____

Species: __Dog __ Cat Breed: _____

Gender: __ Female __ Spayed Female __ Male __ Neutered Male

Age/birthday (if known): _____

Name: _____

Species: __Dog __ Cat Breed: _____

Gender: ☐ Female ☐ Spayed Female ☐ Male ☐ Neutered Male

Age/birthday (if known): _____

Name: _____

Species: ☐ Dog ☐ Cat Breed: _____

Gender: ☐ Female ☐ Spayed Female ☐ Male ☐ Neutered Male

Age/birthday (if known): _____

Name: _____

Species: ☐ Dog ☐ Cat Breed: _____

Gender: ☐ Female ☐ Spayed Female ☐ Male ☐ Neutered Male

Age/birthday (if known): _____

Previous medical history: You may receive an email request from Pawprint, our medical record app partners, for information regarding past medical history and previous veterinarians you may have visited with your pets. Previous medical records will allow us to get the most detailed history of problems and accurately document wellness care reminders. If you have digital copies of these already or are requesting them from your previous provider, feel free to send them to us at okobojivet@gmail.com or bring physical copies with you to your appointment (previous invoices can be helpful in identifying procedures and medications used, but medical histories are preferred for best medical documentation). Additionally, if you are more comfortable with us contacting your previous provider on your behalf, you may enter their information below:

Previous clinic name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: (____) _____ Email (if known): _____

Any alternative names you or your pets' information may be under?

Previous clinic name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: (____) _____ Email (if known): _____

Any alternative names you or your pets' information may be under?

Fear Free Pre-visit Questionnaire

This section is optional; however, as a veterinary clinic striving to understand and mitigate stressful situations for our patients, this information is important in understanding patient needs and ultimately serve you and your pet more effectively. To fill out the questionnaire, please continue to the next page.

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PRE-VISIT QUESTIONNAIRE



Date: _____

Client Name: _____ Pet's Name: _____

As a Fear Free Certified Professional team, we want to make you pet's veterinary experience as enjoyable and as stress free as possible. As such, it's important for us to understand what your pet might find upsetting. The information will help us to adjust our care to better serve and comfort your pet. Please answer the following questions to the best of your ability so we can take into consideration both your & your pet's preferences.

Does your pet show any reluctance to getting in the carrier or car? Yes No

How and where does your pet travel in the car? (carrier, seatbelt, loose, etc.): _____

During travel to the veterinary hospital, does your pet do any of the following:

Eager & excited	Reluctant	Hide	Drool	Vomit	Urine/BM	
Subdued	Bark/Meow	Whine	Pant	Tremble	Pace	Other _____

Does your pet prefer:

Female veterinary professional Male veterinary professional It doesn't matter

Check any situations listed below that your pet has shown avoidance or dislike of in the past. You can add additional comments at the end.

Getting in their carrier or the car	Going into the exam room
Entering the veterinary hospital	Being put up on the table for examination
Other pets and/or people passing by while in reception/check-in	Having direct eye contact with the technician and/or veterinarian
Waiting with other people and animals in the waiting area	Loud voices during examination
Being approached by veterinary staff	Having a rectal temperature taken
Getting on the scale for a weight	The use of instruments such as the stethoscope or otoscope (to look in the ears)
Hearing the doorbell, overhead intercom, or phones ringing	Being taken out of the exam room for procedures
Sounds coming from the back areas of the practice	

How would you describe your pet around other animals and people?

Does your pet have any sensitive areas that s/he does not like to have touched by you or others?

Are there any procedures your pet has not liked having performed at the veterinary hospital in the past or that seemed difficult for you or the staff to do? (nail trims, weight, temperature, ear exam, blood draw) If so, how did you pet react?

What are your pet's favorite treats? (Please bring some to your next visit to our hospital):

Does your pet like to play with toys? If so what kinds?

Has your pet ever been prescribed any supplements or medications to help with a visit to the veterinary hospital? If so, what was it and what sort of results did you experience?

Anything else you would like us to know? _____

VETERINARY HEALTHCARE TEAM: Transfer all applicable information from questionnaire to the patient's Fear Free Emotional Medical Record.