Dr. David Feldman D.C.
Certified Animal Chiropractor
www.mypetschiropractor.ca

YOUR PET'S HEALTH HISTORY

Date: _____

Pet Name: _____ Pet Type: Dog: ( ) Cat: ( ) Specify: _____

Age: _____ Sex: M: _____ F: _____ Breed:_____

Owner's Last Name_____ First Name: _____

Address: _____

City:_____Prov:_____ Postal Code: _____

Phone: H: _____ W: _____ C: _____

Has your pet had any previous Animal Chiropractic treatments done? Yes_____ No_____

Is your pet neutered | spayed *(Please Circle)*

Is your pet presently on any medications? Please List _____

Is your pet on a special diet? Yes ( ) No ( ) What type? _____

Is your pet up to date on their vaccinations? Yes ( ) No ( )

Name of Veterinarian: _____

Clinic_____ Phone: _____

Pet Health History:

Chief Complaint:

_____

_____

When did this condition begin? _____
Was this condition caused by recent trauma? _____
Is there a history of any previous trauma or illness? _____
Has your pet been examined by their veterinarian for this condition? Yes ( ) No ( )
When? _____ Any testing done? _____
Was any treatment given? _____

Please check if your pet has had any of the following:

_____ change in eating habits	_____ change in personality	_____ problems with vision/hearing
_____ swelling or heat in any joints	_____ has become lethargic	_____ has difficulty swallowing
_____ history of biting/aggression	_____ bowel/bladder problems	_____ limping/gait issues

Please circle the level of exercise of your pet: MILD MODERATE VERY ACTIVE