

Client:

Patient:

Date:



DROP-OFF HISTORY QUESTIONNAIRE

Nature of problem: _____

Symptoms are? Improving_____ Worse_____ Same_____

Treatments? _____

Any improvement with treatment? Yes_____ No_____

Similar problem previously? Yes_____ No_____

Change in appetite? Yes_____ No_____ If so: Increase____ Decrease____

Change in water consumption? Yes_____ No_____ If so: Increase____ Decrease____

Change in activity level? Yes_____ No_____ If so: Increase____ Decrease____

Vomiting? Yes_____ No_____ If so Frequency_____

Diarrhea? Yes_____ No_____ If so Frequency_____

Coughing? Yes_____ No_____ If so Frequency_____

Sneezing? Yes_____ No_____ If so Frequency_____

Recent change in diet? Yes_____ No_____ If so what kind?_____

When did your pet last eat? Yes_____ No_____

Any other pets in the household? Yes_____ No_____ Similar symptoms? Yes____ No____

Nature of problem: _____

Number where you can be reach today. _____