# Goodwill Healing

## *Applied Clinical Therapeutics*
## *Small Animal Intake*

***747 Hyde Park Rd., Suite 111 London, Ontario***

*All information is strictly confidential and cannot be released to anyone without your written consent. If at any time you have any questions, feel free to ask.*

Name of Owner:_____

Name of Pet: _____

Species Type: _____

Breed: _____

Sex/ Alterations (fixed): _____

Age/ DOB:_____

Address :_____

City_____ Postal Code _____

Home Phone:_____
Work Phone:_____
Cell Phone:_____

E-Mail : _____

Veterinarian/ Clinic: _____
Phone: _____

Do you give your permission for Goodwill Healing to contact your animals' veterinarian for the exchange of clinic information? Yes/ No

Please describe your primary concern (reason for treatment)

When did the problem start (onset and duration)?

What was the mechanism of injury (how did it happen)?

How has the injury progressed?

What makes the symptoms better or worse?

Please list any previous surgeries:

Please list any previous injuries:

Please list any medications or supplements your pet may be taking:

Please describe your pets lifestyle (working, leisure, athletic):

Have you noticed any behavioral changes in your animal lately? Yes/No
If yes, please describe _____

Have there been any recent stressors to your animal (example a recent move or schedule change), please
describe:_____
_____

Any changes in your animals appetite: Yes/ No
Any abnormal vomiting: Yes/ No
Any Abnormal stool: Yes / No
Any coughing/ sneezing/ abnormal breathing: Yes/ No
Does your pet like to exercise as normal: Yes/ No
Any unintentional weight gain or loss: Yes/ No
Any new pets introduced recently: Yes/ No
Any excessive drinking or urination: Yes/ No
Any inability to weight bear: Yes/ No
Any neurological symptoms: Yes/ No
If yes, please describe _____
Is there any potential your animal is pregnant: Yes/ No
Is the animal fed a is raw diet: Yes/ No

Please circle any of the following that apply:
My animal is slow to rise
My animal struggles to lie down
My animal struggles to turn – please indicate direction (R/L)
My animal struggles with stairs – up or down
My animal struggles to change speed
I feel my animal is in pain or has weakness
My animal struggles to maintain balance

Please circle any of the following characteristics that describe your animal:

| | | |
|---|---|---|
| Friendly | Protective | Food Driven |
| Hyper | Easily Distracted | Painful to Touch |
| Easily Stressed | Mouthy (likes to nibble) | |

**Vaccination Policy**
Please note that this clinic has a strict vaccination policy. Please indicate that your animal has the following vaccines:

**Canine:**
Rabies Y/N
Distemper Y/N
Hepatitis Y/N
Parovirus Y/N
Bordatella Y/N

**Feline:**
Rabies Y/N
Feline rhinotrachetis, calicivirus, and chlamydia Y/N
Feline leukaemia and immunodefiency Y/N

I _____(name of owner) declare that my pet _____( name of pet) is up to date on their appropriate vaccinations.
_____(signature) _____(Date)

**Parasite Policy**
Please note that this clinic also has a strict parasite control policy. Animals are required to have flea and tick protection. If you suspect that your animal has a parasite infection please cancel your appointment immediately. If you are made aware of a parasite infection post treatment, please immediately notify the clinic.

**Restraint Policy**
This clinic has a strict restraint policy. Animals must remain on a leash or in a carrier at all times, unless directed by the treating osteopathic manual therapist.

I _____(owners name) hereby consent to having my animal _____(animals name) receive osteopathic manual treatment.

_____(signature) _____ (date)