



WAGGING TAILS VETERINARY SERVICES

PATIENT INTAKE FORM

Client Information:

NAME:	PHONE:
EMAIL:	ADDRESS:

Patient Information:

Name:	Breed:			
Age:	Approximate weight (in lbs):			
Circle One	Neutered Male	Spayed Female	Intact Male	Intact Female

Desired Therapy Goals:

Household Environment (carpet, hardwood, stairs):

Current Daily Activity (eg. How many walks a day, length of time, any other exercise):

Current Diet (brand, volume and frequency):

Current or past medical issues:

Medication or supplements	Dosage		Frequency of administration

Authorization Waiver:

Wagging Tails Veterinary Services has disclosed to me the nature of holistic and complementary therapies and rehabilitative veterinary medicine. I authorize Wagging Tails to use the recommended rehabilitative and complementary treatments on my pet.

I understand that Wagging Tails recommendations and treatments of my pet constitute no guarantee of results. I further understand that my pet's recommendations and treatment are based, to some degree, on the information that I supply.

In consideration of the foregoing, I waive and release any and all rights, claims, and causes of action I have or may have against Wagging Tails and its affiliates, officers, directors, employees, representatives, successors and assigns, that may arise as a result of any of Wagging Tails recommendations or treatment of my pet, including, but not limited to any acupuncture, therapeutic exercise, or other treatments or care.

Signature

Date