peak performance
ANIMAL CHIROPRACTIC

Dr. Sarah Wuest
BA, DC, Sport Sciences Resident
International Veterinary Chiropractic Association
Certified Animal Chiropractor

PATIENT INTAKE FORM

Client Information

To help us provide the best care, please complete the following:

Client First and Last Name(s) ______________________________

Street Address ______________________________

City ______________ Province ______________ Postal Code ______________

Home Phone ______________ Work Phone ______________

Cell Phone(s) ______________________________

Fax ______________ Email ______________

How did you hear about Peak Performance Animal Chiropractic? ______________

Name of PRIMARY Veterinarian ______________________________

Contact Information for Primary Veterinarian ______________________________

____

Patient Information

Patient Name ______________ Species ❒ canine ❒ equine ❒ feline ❒ other ______

Breed ______________ Sex ❒ male ❒ female Spayed/Neutered ❒ yes ❒ no

Patient's Birth Date or Age ______________ How long have you owned your pet? ______________

Patient Colour and Markings ______________________________

24 Harrow Cres SW
Calgary AB, T2V 3B1

T: 403-700-2486
F: 587-352-7873
E: peakperformchiro@gmail.com
www.peakperformancechiro.ca

Patient Medical History

What are the patient's symptoms? ______________________________

When did you first notice these symptoms? ______________________________

Are the symptoms ❒ getting better ❒ getting worse ❒ staying the same

What makes the symptoms better ____________________ worse ____________________

Is the patient currently diagnosed with any medical problems? ❒ no ❒ yes

- If yes, what type and when? ______________________________

____

Is the patient currently on any medications? ❒ no ❒ yes (please list) ____________________

Has the patient been treated for any medical problems in the past? ❒ no ❒ yes

- If yes, what type and when? ______________________________

____

Has the patient lost or gained weight recently? ❒ no ❒ yes– Gained ❒ yes – Lost

Has the patient's water intake changed? ❒ less ❒ more ❒ no change

Has the patient's urinary or bowel habits changed? ❒ less ❒ more ❒ no change

Has the patient experienced any vomiting? ❒ no ❒ yes

Has the patient experienced any seizures? ❒ no ❒ yes

- If yes, when was the first seizure? ____________ the last seizure? ____________

What type of food do you currently feed? ______________________________

Is the patient kept ❒ Indoors (including Stable) ❒ Outdoors

Statement of Ownership

I am the owner and/or caregiver of the above animal and have the legal authority to consent to treatment.

Name ____________________ Signature ____________________ Date ____________

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