Continental
Animal Wellness Center

Thank you for giving us the opportunity to care for your pet. We'll be happy to answer any questions you have about your pet's health. To insure the best care possible, please take the time to fill in this form completely. Thank you!

REGISTRATION

Owner:_____

Date:_____

Address:_____ City: _____ State:_____ Zip Code:_____

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

Spouse:_____

_____

Cell Phone:_____ Home phone:_____

Work Phone:_____

Email (to sync records with PetDesk):_____

Emergency contact & Phone:_____

How did you hear about us?_____

Number of pets: Dogs:_____ Cats:_____ Other (Specify):_____

Reason for visit?_____

_____

PET HEALTH HISTORY

Name of pet _____ Dog __ Cat __ Other __

Breed _____ Color_____ Date of Birth _____

Male _____ Neutered _____ Female _____ Spayed _____

Vaccination History (Date and type of last vaccination) _____

Pet's current medications

_____

Describe your pet's diet

_____

Please check any symptoms or problems that you have noticed about your pet:

___ Behavioral Problems ___ Lack of Appetite ____ Sneezing

___ Bleeding Gums ___ Limping ____ Thirst &/or Urinating increased

___ Breathing Problems ___ Loss of Balance ____ Vomiting

___ Coughing ___ Scooting ____ Weakness

___ Diarrhea ___ Scratching ____ Other_____

___ Eye Bulging or Bloodshot ___ Seems Depressed

___ Gagging ___ Shaking Head