



Client Information

File # _____

Date _____

Last Name _____ First Name _____

Spouse or Significant Other _____

Address _____ City _____

County _____ State _____ Zip _____

Home Phone _____ Best time to call _____

Work Phone _____ Cell Phone _____

Email _____

Driver's License # _____ State _____

Place & Address of Employment _____

How did you find out about us? _____

If referred, by whom _____

Other Animal Hospital & Veterinarian _____

Why did you choose us? _____

General attitude towards Holistic Therapy (circle): **Positive** **Neutral** **Negative**

Interested in (please circle): Chiropractic Acupuncture Herbal Homeopathy

Other Modality _____

To the best of my knowledge, the information provided above and on the patient history form is accurate and complete. I authorize you to contact my referring veterinarian if clarification of medical history is needed or to acquire previous veterinary records, I understand that payment is due at the time services are rendered. I agree to pay all charges at the time my pet is discharged.

Client Signature

Date