Account #_____

PAWS VETERINARY CLINIC

3102 E. 7TH ST, STE 300
JOPLIN, MO 64801

417.626.2828
WWW.PAWSV.COM

DROP OFF FORM

Today's Date: _____

Client's Name: _____ Pet's Name: _____

Contact Phone Number: _____

Belongings: _____ How will you be paying? Cash Check Visa/MC Care Credit

Weight: _____ Location: _____Staff Member Checking In: _____

Patient Warning/Special Care: _____

The information requested tells us the things you want us to do for your pet. It is the only way we can be certain that we understand what you want. Therefore, it is **VERY IMORTANT** for you to be as specific as possible. If we need any additional information, we will contact you, so please be sure to leave us a number that you can be reached at today. If you will be dropping off your pet for exam and vaccinations there will be a day board charge.
Thank You.

Reason for Exam: (circle one) Hurt Sick Vaccinations Other

Services/Vaccinations needing updated (circle):

Canine: Distemper Parvo Rabies Bordetella Inj. Nasal Bordetella **Semi**-annual Fecal Annual Heartworm test Heartworm/Flea & tick prevention

Feline: Feline Distemper Rabies Feline Leukemia Semi-annual Fecal Heartworm Prevention Flea and tick prevention

Has your pet eaten today? YES OR NO What/ when /how much? _____

What is your pet doing?

_____**Coughing / sneezing** **How long/how often/ any discharge?** _____

_____**Vomiting** **How long/how often/how much?** _____

_____**Diarrhea** **How long/how often/ appearance?** _____

_____**Eating** **How much/how often/ more or less than normal /any changes?** _____

_____

_____**Treats** **What kind/how often/any changes?** _____

_____**Drinking** **More or Less than normal/how long?** _____

_____**Urinating** **More or Less than normal/how long?** _____

_____**Defecating** **Normal or abnormal/ How long?** _____

_____**Exercise/Activity Level** **Normal or abnormal/ How long?** _____

_____**Ears/Skin** **How long/where?** _____

_____**Licking/Scratching** **How long/where?**_____

_____**Lumps/bumps** **How long/where/changes in appearance/size?** _____

_____**Limping** **How long/which leg?** _____

_____**Other** _____

Please list any medications/supplements that your pet maybe taking along with name, dosage, and frequency.

Do we have your permission to run the following diagnostics if your pet is in need of them? (Please circle all that apply)

CBC CHEMISTRY FECAL URINALYISIS X-RAY EAR SWAB HEARWORM TEST

If there is any other information that you feel the Doctor needs to know, please tell us:

_____

SIGNATURE OF OWNER/AGENT: _____DATE: _____