

PHS SINGLE CAT PROFILE

Separate form for each pet: __ of __

Date: _____ Account # _____

Owner: _____ Pet Name: _____

Length of Time Owned: _____ Sex: M/F Spayed/Neutered Y/N

Birth date: _____ Or Age: _____ Weight: _____ Or Size: _____

Description: _____

Vaccinations (month/yr): _____ Pet Allergies: _____

License #: _____ Microchip/Tattoo/Tag #: _____

Pet Medical History: (ongoing or reoccurring known illnesses/injuries, treatments & medications) _____

Emergency Care (*Only if different from primary Vet listed on client profile*)

Vet Name: _____ Clinic Name: _____

Phone: _____ Location: _____

Feeding Instructions:

Feed apart from other pets/supervise Dispose of uneaten food

Remove food after _____ Min

<input type="checkbox"/> Dry Brand: Measure with: Amount: Where to feed:		<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Dusk <input type="checkbox"/> Night	Procedure:
<input type="checkbox"/> Wet Brand: Measure with: Amount: Where to feed:		<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Dusk <input type="checkbox"/> Night	Procedure:
<input type="checkbox"/> Medication(s) Amount: Location: Hide In Treat:		<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Dusk <input type="checkbox"/> Night	Procedure:

<input type="checkbox"/> Medication(s) Amount: Location: Hide In Treat:		<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Dusk <input type="checkbox"/> Night	Procedure:
<input type="checkbox"/> Water	<i>Water will be cleaned and filled frequently</i>	<input type="checkbox"/> Tap <input type="checkbox"/> Bottled <input type="checkbox"/> Filtered	Dish Location: Water Location:
<input type="checkbox"/> Treats Kind: Amount: Location:		Notes:	

Pet's Living Area:

<input type="checkbox"/> NOT allowed outdoors at all <input type="checkbox"/> Allowed on furniture, counters, beds <input type="checkbox"/> Restrict pet area at all times <input type="checkbox"/> Restrict pet area only when pet is alone	Restricted Area/Crate Location: _____ _____ Other off-limit areas: _____ _____
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Locations of:

Litter Box : _____
 Litter Disposal Method: _____
 Kitty Litter: _____
 Toys: _____
 Brush: _____
 Other: _____

Temperament/Personality: _____

Pet Doesn't Like:

- | | | |
|---------------------------------------|--|--|
| <input type="checkbox"/> Brushing | <input type="checkbox"/> New Animals | <input type="checkbox"/> Loud Noise / Vacuum / Thunder |
| <input type="checkbox"/> Massage | <input type="checkbox"/> Other family pets | <input type="checkbox"/> All Humans |
| <input type="checkbox"/> Ears Touched | <input type="checkbox"/> People near food dish | <input type="checkbox"/> Strangers |
| <input type="checkbox"/> Scratching | <input type="checkbox"/> Sharing food | |

Pet reacts to the above by: _____

Has Pet Ever:

Describe

- Attacked/bit someone _____
- Attacked another animal _____
- Injured self /escaped from fear _____
- Injured self out of boredom _____
- Escaped from home _____

Where does he/she like to escape to/hide? _____

How can he/she be retrieved? _____

Favorite Games, Toys, and Activities:

Comments: _____
