Desert Shadows
Chiropractic & Wellness

Animal History Form

Please bring this completed form to your appointment

Animal's Name: _____ Breed: _____ Sex: Male Female

Owner's Name: _____ Cell Phone #:_____ Age of Animal: _____

Address:_____

Email: _____ How were you referred: _____

Veterinarian: _____ Veterinary Clinic_____

Please share your observations of your pet's condition below:

HISTORY:

Your Concerns/pet's current problem(s)_____

Duration and frequency of problem(s)_____

Problems: Same / Better / Worse

Had similar problems in the past? Explain _____

What was the treatment? _____

Was the treatment affective? _____

Current medications & supplements: _____

COMMENTS:

_____

_____

_____

_____

_____

_____

Consent

By submitting this form, I understand that I am authorizing Dr. Campo, DC, CAC to examine and treat the above-described pet. I assume full responsibility for all charges incurred in the care of this animal. I understand that charges must be paid in full at time of service.

Sign: _____ Date: _____

Dr's Comments: _____