

Canine Lifestyle Assessment Form



For Office Use Only:

- Review by Technician
- Review by Veterinarian

Pet owner name: _____

Name of dog: _____ Date of birth: ____/____/____ Date of last preventive care visit: ____/____/____

Breed: _____ Mixed breed Male Female Spayed/neutered

1. How many dogs live in your home? _____
2. How many cats? _____
3. Other pets in the household include: _____

TRAVEL AND OUTDOORS

4. How much time does your dog spend outside every day? _____ hours
5. Do you take your dog to any of the following (check all that apply):
 Dog parks Doggie day care Boarding or grooming facilities Puppy school Obedience training Organized competitions
6. Do you travel with your dog? Yes No Where do you go? _____
7. Do you take your dog hiking, hunting, camping, or fishing? Yes No

HOME ENVIRONMENT AND HOME CARE

8. Do you observe wild animals or other wildlife in your neighborhood?
 Feral cats Squirrels, chipmunks, skunks, or small rodents Raccoons Deer Wild turkeys Wild canines (coyotes, foxes)
 Other _____
9. Do you or your dog visit homes where there are pets? Yes No
10. Do other pets come to visit at your house? Yes No
11. Do children, elders, or people with weakened immune systems live in or visit your home? Yes No
12. Have you seen fleas or ticks on ANY of your pets in your home? Yes No
13. Have you seen worms in your dog's poop or on their back end? Yes No
14. Which pets do you treat for fleas, ticks, internal parasites, or heartworms? Dog(s) Cat(s)
15. How often do you treat your pets for fleas, ticks, internal parasites or heartworm? Seasonal Year-round When I remember Other _____
16. Please list all products, medications, or supplements your dog is using.
 Flea or tick control products _____
 Pain medications (including prescriptions and aspirin) _____
 Dental products (including chews) _____
 Heartworm preventive _____
 Supplements (including herbs, natural remedies, CBD) _____
 Others _____
17. What kind of food do you feed your dog? Dry _____ Canned _____ Raw _____ Homemade _____
18. Do you feed your dog treats? Yes If so, how many times per day? _____ No
19. What kind of exercise does your dog get? _____
20. Do you brush your dog's teeth? Yes If so, how often? _____ No Has your dog had their teeth scaled while awake? Yes No

UNUSUAL BEHAVIOR

21. Does your dog scratch, bite at their skin, or seem "itchy"? Yes No
22. Does the sound of your dog's clanking tags wake you up at night? Yes No
23. Have you noticed
Any weight loss or gain? Yes No
Any change in your dog's skin or hair coat? Yes No
Any recent change in your dog's behavior? Yes No
Any recent change in your dog's activity level? Yes No
Any signs of pain, including slow to get up or down, or hesitant to jump into or out of the car or onto or off of the bed? Yes No
Any signs of tremor or weakness in the rear legs? Yes No
Any recent changes in your dog's behavior when defecating or urinating? Yes No
Any recent changes in your dog's behavior toward you, other family members, other pets, or strangers? Yes No
Has your dog seemed "grumpy", or started to shy away from physical touch and petting? Yes No
Please describe the changes: _____

When complete, save in client's folder.