

Feline Lifestyle Assessment Form



For Office Use Only:

- Review by Technician
- Review by Veterinarian

Pet owner name: _____

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

Breed: _____ Mixed breed Male Female Spayed/neutered

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

TRAVEL AND OUTDOORS

4. How much time does your cat spend outside every day? _____ hours
5. Do you take your cat to any of the following (check all that apply):
 Organized events or competitions Day care Boarding or grooming facilities
6. Do you travel with your cat? Yes No Where do you go? _____
7. Do you take your cat on any outdoor activities? 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 cat 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, ticks, or worms on ANY of your pets in your home? Yes No
13. Have you noticed any fleas or ticks on your cat? Yes No
14. Which pets do you treat for fleas, ticks, internal parasites, or heartworms? Cat(s) Dogs(s)
15. How often do you treat your pets for fleas, ticks, internal parasites or heartworm? Seasonal Year-round When I remember Other _____
16. Does your cat use a litterbox, go outside, or both? _____
17. Please list all products, medications, or supplements your cat 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 _____
18. What kind of food do you feed your cat? Dry _____ Canned _____ Raw _____ Homemade _____
19. Do you feed your cat treats? Yes If so, how many times per day? _____ No
20. What kind of exercise does your cat get? _____
21. Do you brush your cat's teeth? Yes If so, how often? _____ No Has your cat had their teeth scaled while awake? Yes No

UNUSUAL BEHAVIOR

22. Does your cat scratch, bite at their skin, or seem "itchy"? Yes No
23. Have you noticed
Any weight loss or gain? Yes No
Any change in your cat's skin or hair coat? Yes No
Any recent change in your cat's behavior? Yes No
Any recent change in your cat's activity level? Yes No
Any signs of pain, including slow to get up or down, or protecting of a certain body part? Yes No
Any signs of tremor or weakness in the rear legs? Yes No
Any recent changes in your cat's behavior when defecating or urinating? Yes No
Any recent changes in your cat's behavior toward you, other family members, other pets, or strangers? Yes No
Has your cat 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.