



Client Information

Name: _____		
Street Address: _____		
City: _____	State: _____	Zip Code: _____
Work Phone: _____	Home Phone: _____	Cell: _____
Email Address: _____		

Pet Information

Pet Name: _____		<input type="checkbox"/> Cat <input type="checkbox"/> Dog <input type="checkbox"/> Bird <input type="checkbox"/> Other: _____
Sex: <input type="checkbox"/> Female (Spayed? <input type="checkbox"/> Yes <input type="checkbox"/> No)	<input type="checkbox"/> Male (Neutered? <input type="checkbox"/> Yes <input type="checkbox"/> No)	
Color: _____	Breed: _____	
Pet's Date of Birth: _____	Pet's Weight: _____	
Pet's Collar Color/Description: _____		
ID Tags Attached to Collar? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Is your pet microchipped? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please provide your pet's assigned microchip number and the company with which your pet is registered: _____		
Favorite Toys: _____		
Personality: _____		
How does your pet react to your absence from the home? _____		
Has your pet ever snapped at or bitten anyone? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please describe the circumstances: _____		
Is your pet good with children? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		
Does your pet have a history of biting or fighting with other animals? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please explain: _____		
Are you aware of any reason we should approach your pet with caution? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please explain: _____		

Feeding Instructions

A.M.: _____
Midday: _____
P.M.: _____
Brand of Pet Food Used: _____ Where is the food stored? _____
May the pet sitter give treats to your pet? Yes No
If yes, where are the treats stored? _____

Exercise

Daily Exercise Instructions:

Location of leash/harness:

Medical Information

Veterinary Clinic Name: _____ Phone Number: _____
Date of Most Recent Rabies Shot: _____
Date of Most Recent DHLPP Shot: _____
Does your pet have a history of illness? Yes No
If yes, please explain:

In the rare case of an emergency involving your pet, where you would prefer to have your pet treated?
Emergency Veterinary Clinic Name: _____
Address: _____
Phone Number: _____
I authorize Saint Louis Dog Walkers to follow the recommendations of this veterinary clinic and I agree to pay all costs, expenses, etc. as recommended by this veterinary clinic.
Initial: _____
Does your pet take medication? Yes No
If yes, where is the medication stored?

Please list your pet's medication

Name of Medication	When to Administer	Amount	How to Administer