

**MARY "MAMIE" WHITMAN, PT, CCRT**

Certified Canine Rehabilitation Therapist

Dog Rehab Works, LLC

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**CLIENT REGISTRATION FORM**

Owner Name:	Email:
Address:	
Phone:	Cell:
Dog's Name:	
Sex: M F	Age:
Spayed/Neutered: Y N	Weight:
Breed:	Color:
Problem/ Diagnosis:	Veterinarian Name:/ Clinic Name:

Where did you hear about me? \_\_\_\_\_

Please describe the current problem for which your dog is being seen:

\_\_\_\_\_  
\_\_\_\_\_

When did the problem begin? \_\_\_\_\_

How did it happen? \_\_\_\_\_

MEDICAL HISTORY

Is your dog taking any medications, vitamins, or supplements? If so:

Name	Dose	Purpose
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any surgeries, illnesses, or medical problems (include dates)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are your dog's immunization/vaccines current? Yes No

If using titers, are these current? Yes No