



OUT OF THE DOG HOUSE

Professional Pet Sitting and Dog Walking

Email: vicki@outofthedoghousect.com Website: www.outofthedoghousect.com 860-838-4269 or
413-358-3233 (Cell)

Today's date: _____

Cat's Name: _____ Sex Male Female

Age/birthday: _____ How long have you had your pet? _____

Spayed Neutered Is your pet micro chipped? Yes No Not sure

Veterinarian name: _____ Tel: _____

Is your pet current on Rabies shots? _____

Breed: _____ Color(s): _____ Declawed? Yes No

If your pet looks similar to another, how do you tell them apart? _____

Any health concerns, medicines or food allergies I should know about? Yes No _____

Feeding instructions:

Feed apart from other pets Dispose of uneaten food Remove food after _____ min.

<input type="checkbox"/> Dry Brand: _____ Measure with: _____ Amount: _____ Where to feed: _____	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night	Procedure: _____ Procedure: _____
<input type="checkbox"/> Wet Brand: _____ Measure with: _____ Amount: _____ Where to feed: _____	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night	Procedure: _____ Procedure: _____

Treats? Where are they kept and how many? _____

Does your cat have a particular dish or bowl? If so, please describe _____

Favorite toy, games and activities: _____

Does your litter box require changing during my service? Yes No If yes, what is your normal procedure? _____

Location of box, scoop and bags _____

<input type="checkbox"/> Medication(s) Dosage: Location: Hide in treat:	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night	Procedure:
<input type="checkbox"/> Medication(s) Dosage: Location: Hide in treat:	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night	Procedure:

Pets living area:

<input type="checkbox"/> Only allowed outdoors on a leash <input type="checkbox"/> Invisible fence, let out with collar <input type="checkbox"/> Let out, secure fence <input type="checkbox"/> Let out, no fence won't leave yard <input type="checkbox"/> Not allowed indoors	<input type="checkbox"/> Allowed on furniture, beds <input type="checkbox"/> Restrict pet area, crate when pet is alone <input type="checkbox"/> Restrict pet area/crate at all times Restricted area/crate location: Other off limit areas:
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My pet doesn't like:

<input type="checkbox"/> Touch feet	<input type="checkbox"/> Touch ears	<input type="checkbox"/> New animals	<input type="checkbox"/> Other family pets
<input type="checkbox"/> Sharing food dish	<input type="checkbox"/> Loud noises	<input type="checkbox"/> Thunder	<input type="checkbox"/> People near food dish
<input type="checkbox"/> Strangers	<input type="checkbox"/> Vacuum	<input type="checkbox"/> Other _____	

Has your pet ever:

<input type="checkbox"/> Attacked someone/bit someone	<input type="checkbox"/> Attacked another animal
<input type="checkbox"/> Injured self/escaped out of fear	<input type="checkbox"/> Injured self out of boredom
<input type="checkbox"/> Escaped from home If so, how can your pet be retrieved? _____	

Describe, even if mild or under extreme or unusual situations