

Patient Intake Form for BICOM[®] 2000 Therapy

Client Information

First name:	Last name:	
Address:		
City:	State:	ZIP:
Home phone: ()	Work phone: ()	Cell: ()
E-mail:		
How did you hear about BICOM?		
<input type="checkbox"/> Referred by primary care veterinarian, _____		
<input type="checkbox"/> Friend, whom may we thank? _____		
<input type="checkbox"/> Yellow pages <input type="checkbox"/> Drove by <input type="checkbox"/> Brochure <input type="checkbox"/> Website <input type="checkbox"/> Current client		
Primary care veterinarian:	Phone: ()	
Hospital:		

Patient Information

Patient's name:	Birth date or age:	
Species: <input type="checkbox"/> Dog <input type="checkbox"/> Cat <input type="checkbox"/> Bird <input type="checkbox"/> Small mammal <input type="checkbox"/> Reptile <input type="checkbox"/> Horse <input type="checkbox"/> Other:		
Breed:	Color:	<input type="checkbox"/> Male <input type="checkbox"/> Neutered <input type="checkbox"/> Female <input type="checkbox"/> Spayed
Lifestyle: <input type="checkbox"/> Indoor exclusively <input type="checkbox"/> Indoor/outdoor <input type="checkbox"/> Outdoor exclusively <input type="checkbox"/> Spends long periods in a crate/pen		
Vaccinations and date of administration:		

Patient History

What is your animal's primary health concern? When was the date of onset?
What medications is your animal currently taking? Please list doses and frequency. Include preventatives.
Has your animal had any medication reactions? If yes, please explain.
What food do you feed your animal? Please check all that apply. Brand: <input type="checkbox"/> Dry <input type="checkbox"/> Canned <input type="checkbox"/> Treats _____ <input type="checkbox"/> Table scraps
Has your animal been treated for any major medical problems? If yes, list problem and date.
Has your animal ever had surgery and/or anesthesia (i.e. spay, neuter, professional dental cleaning, etc.)? If yes, list procedures and date.