

Rehabilitation Consult Questionnaire

1. Owner name: _____
2. Pet name: _____
3. What is the primary reason (or diagnosis) for seeking rehabilitation care for your pet?

4. What day was the injury/issue first noticed? _____
5. Since it was first noticed, has the injury/issue improved, worsened, or remained the same in severity? _____
6. What abnormal signs have you seen at home (mark all that apply)?
 - Difficulty walking around your home
 - Difficulty sitting/lying down
 - Difficulty getting up
 - Difficulty going outside for leashed walks
 - Difficulty squatting/lifting a leg to urinate/defecate
 - Difficulty playing with toys and/or other pets
 - Difficulty running
 - Limping for a few minutes
 - Limping for one or more days
 - Weakness
 - Quality of life is affected
 - Other: _____

7. Do you feel your pet is in pain? Yes / No . If yes, on a scale from 0 to 10 (1 being very mild pain, and 10 being very severe pain), where do you think your pet's pain level is at:

- On AVERAGE? _____
- At its WORST? _____
- At its BEST? _____
- Right NOW? _____
- What signs are you seeing that make you concerned your pet is in pain (i.e. yelping, limping, not eating well, avoiding certain movements, etc.)?

8. What activities is your pet CURRENTLY able to do (mark all that apply)?

- Freely roam in your home
- Leashed potty breaks outside
- Leashed walks outside
- Climb up/down furniture
- Climb up/down stairs
- Play with toys and/or other pets
- Off-leash play outside
- Crate confined at night
- Crate confined when unsupervised
- Crate confined majority of the day

9. Prior to the injury/issue, how frequent and how long were the following activities done?

- Leashed walks outside _____
- Play with toys and/or other pets _____
- Off-leash play outside _____
- Competitions (agility, etc.), work, and/or activities (hiking, etc.) _____

10. If we recommend some at-home exercises for your pet, would someone be able to do this? If yes, it's usually recommended they be done multiple times a day. How frequently would someone realistically be able to be able to do these with your pet (i.e. 10 min, twice a day; 30 min, twice a week; etc.)?

11. What is your pet's home environment like (please mark all that apply)?

- Stairs
- Hills/inclines
- Fenced yard
- Hardwood or other smooth flooring
- Carpet flooring
- Other pets
- Other: _____

12. What is the goal you are trying to achieve by going through our rehabilitation services (i.e. return to certain activities, stop/improve limping or pain, etc.)?

13. Is your pet currently on any medications and/or supplements? If yes, which one(s)? _____

14. Are there any previous and/or concurrent medical issues we should be aware of (i.e. cancer, previous surgeries/injuries/illness, etc.)? _____

15. Do you feel your pet is:

- Overweight
- Perfect weight
- Underweight
- Unsure

16. Does your pet have any food allergies? If so, to what? _____

17. Is your pet reactive to other dogs, humans, and/or noises? _____

18. We usually take videos and/or pictures to help us see subtle changes from our patient's first visit to their last. Please let us know your preference:

- I approve videos and pictures of my pet being used ONLY for my pet's medical record and to keep my primary veterinarian updated
- I approve videos and pictures of my pet being used on the hospital's social media accounts and/or website
- I do NOT approve ANY pictures or videos being taken of my pet for any reason

19. How did you hear about our rehabilitation program? _____
