

Every Dog Can, Inc.
Behavior and Training Solutions
for the Family Dog
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Pre-Consultation Questionnaire

Please complete this form as fully as possible and **return it to us via email, fax, or regular mail so we receive it at least 48 hours before your scheduled appointment.** All information is kept in the strictest confidence.

Note: Use the "Save As" command to save this form to your computer. Type your answers directly into the saved form by tabbing or clicking from field to field—the gray text fields will expand to accept unlimited text. Click in the "check boxes" to select an answer. If you prefer, you may print out a hard copy and fill out the form by hand.

Your Information

Today's Date:		
Time and Date of Appointment:		
Your Name:		
Street Address:		
City, State, Zip:		
Phone (with area code): Day:	Evening:	Cell:
Email Address:		
How did you hear about us?		

Your Dog's Information

Dog's Name:
Age (include date of birth if known):
Breed (best guess if unknown):
Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>
Neutered/Spayed: Yes <input type="checkbox"/> No <input type="checkbox"/>
Weight:
Coat Color(s):



Your Dog's Behavior

Describe the issues or problem behaviors for which you are seeking help (please be specific):

Please share the reason or particular incident that's prompting you to seek help at this time:

When did you first notice the problem(s):

Are you or any family members afraid or uncomfortable around your dog? Yes No If yes, please explain:

Training and Behavior Goals

What behaviors and skills would you most like your dog to learn (please be specific):

What would you like to be able to do with your dog that you can't do now:

Your Dog's Medical Information

Date of most recent veterinary exam and results:



Please list any current medical conditions and medications:
Describe any special dietary requirements and/or food intolerances:
Date of most recent Rabies vaccination:
Date and type of other recent vaccinations (DHLPP, Bordetella, etc.):
Your Veterinarian's name:
Name of veterinary hospital or clinic (if applicable):
Street address:
City, State, Zip:
Phone:

Your Dog's Routine

Describe a typical 24-hour day for your dog:
What does your dog do for exercise, and how often and for how long:
How long is your dog left alone on a typical day and what does he do during that time:
What are your dog's favorite foods and treats:



What are your dog's favorite toys:

What are your dog's favorite activities:

Household Members

Please list all **people** living in your household. Please note family relationship, **ages of children under 16**, and any special circumstances such as fragile health, physical challenges, etc.

Name	Relationship	Child's Age	Special Circumstances

Please list all **animals** – including the one you would like help for – currently living in your household. Provide all the information requested, including **how long each has been in your home** and the **order in which they were acquired**.

Name	Species/Breed	Age	M/F	Neutered Y/N	How Long in Home	Order Acquired

Training History



Has your dog had formal training? Yes No If yes, at what age did your dog start:

If yes, check all that apply: Did training myself Puppy Kindergarten Group training class
Private training In-kennel training Other:

If yes, did you get the training results you had hoped for? Yes No If no, to what do you attribute the poor results?

Check all that you use now or have used in the past as training aids:

Chain or nylon choke collar Citronella spray collar Clicker Collar/leash corrections
Electronic shock collar Food treats Games Head halter Harness
Praise Prong or pinch collar Physical corrections (rolled newspaper, hand, etc.)
Pushing your dog's body into position Regular collar Shake can Spray Bottle
Toys Verbal Corrections Verbal reward marker Voice inflection Whistle
Other:

Which training aids do you find to be the most effective with your dog?

Bite History

Has your dog ever bitten a person: Yes No If yes, how many times?

If yes, what part of the person's body was bitten in the worst occurrence:

What was the damage: Scratch Bruise Shallow puncture Deep puncture
Multiple punctures Other:

Was medical treatment sought: Yes No Unknown

Briefly describe the circumstances that led to the bite(s) if not already explained:



Has your dog ever been involved in a dog fight: Yes No If yes, how many times?

Has your dog ever bitten another dog: Yes No If yes, how many times?

If yes, what part of the other dog's body was bitten in the worst occurrence:

What was the damage to the other dog: Scratch Shallow puncture Deep puncture
Multiple punctures Other:

Was veterinary treatment sought for the other dog: Yes No Unknown

Briefly describe the circumstances that led to the bite(s) if not already explained:

Additional Information

Please share any additional information or comments that you feel would be helpful:

Thank you for completing our Questionnaire. We look forward to working with you!