Virginia Scrivener DVM
Certified Canine Rehabilitation Practitioner
Certified Veterinary Pain Practitioner
Certified Veterinary Medical Acupuncturist
www.AnimalRehabVet.com
27 East Baltimore Street ◆ PO Box 841
Funkstown, MD 21734
301-745-8975

Questionnaire

Why are you bringing your pet in for rehab therapy?

1. What problems or issues are you seeing?
   ____
   ____
2. When did the problem first arise?
   ____
   ____
3. Is it worse in the mornings or evening?
   ____
4. How has the problem developed since first noticed?
   ____
   ____
   ____
5. What are YOUR goals for your pet with physical therapy?
   ____
   ____
   ____

Home Environment

1. What type of floors do you have?
   ____
2. Where does your pet sleep?
   ____
3. Do you have stairs in your home? Y or N
   a. Does your pet have to use them daily? Y or N
4. What do you feed your pet and how much?
   ____
   a. What treats does your pet like?
      ____
   b. Does your pet have any allergies? Y or N If yes what kind?
      ____
5. Do you take your pet for walks? Y or N
   a. If yes, how long of a walk? ______min. Is your pet walked On or off of a leash?__ __________________
   b. Do the noticed symptoms or lameness worsen after taking a walk?
      ____
   c. Does your pet tire quickly or have to make many stops on walks?
      ____

6. Has your pet's behavior changed with: *(Please check all that apply)*

- ☐ Family members
- ☐ Other dogs
- ☐ Visitors
- ☐ Loud noises
- ☐ Strangers
- ☐ Traffic
- ☐ Children
- ☐ Going to the vets
- ☐ People passing by the house
- ☐ Being groomed/having nails clipped
- ☐ Being left alone

Physical Assessment

Please rate from 1 (with difficulty) to 5 (without difficulty)

1. How well is your pet able to position to urinate or defecate?	1	2	3	4	5
2. How well is your pet able to transition from a lying position to a standing position and vice versa?	1	2	3	4	5
3. How well does your pet go up and down stairs?	1	2	3	4	5
4. How well is your pet able to get in and out of the car?	1	2	3	4	5
5. Is your pet able to get on/off the couch or bed without assistance?	1	2	3	4	5
6. Is your pet able to run or jump?	1	2	3	4	5

Medical History

1. Are you administering any medications or supplements (including aspirins and glucosamine supplements) at this time? *(if yes please list the medications, dosages and how often they are given)*

Medication/Supplement	Dose	How often given

2. Have there been any previous diagnoses, surgeries or treatments?

____
____
____
____

3. What is your impression of your pet's degree of pain? _______