



## Lincoln Land Animal Clinic, Ltd.

Animal Behavior Services

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## Feline Behavior History Form

Owner Information	
Name:	
Address / City and State:	
Home and Cell Phone:	Home:                      Cell:
Employer's Name:	
Employer's Address City, State and Zip:	
Work Phone:	
Email:	
Preferred method and time to contact you	Method:                      ; Time:
Preferred Local Pharmacy:	Name:                      Phone #:                      Fax #:
Family Veterinarian	Name:                      Phone #:                      Fax #:
Referred by:	Email:
	Name:
Basic Patient Information	
Patient's Name:	
Age:	
Breed & Color:	Breed:                      Color:
Sex:	<input type="checkbox"/> Female <input type="checkbox"/> Male
Spayed or Neutered:    Age when performed:	<input type="checkbox"/> Spayed <input type="checkbox"/> Neutered                      Age:
Is your cat declawed? If so at what age?	<input type="checkbox"/> No <input type="checkbox"/> Yes; <input type="checkbox"/> Front <input type="checkbox"/> Back <input type="checkbox"/> Both; Age:
Weight:                      Body Condition Score:	lbs                      kg <input type="checkbox"/> Very Thin <input type="checkbox"/> Thin <input type="checkbox"/> Normal <input type="checkbox"/> Overweight <input type="checkbox"/> Obese
Date and Age when acquired (if known):	Date:                      Age:
How long have you owned the pet:	
Source:	<input type="checkbox"/> Own breeding <input type="checkbox"/> Breeder /Cattery <input type="checkbox"/> Private home <input type="checkbox"/> Pet shop <input type="checkbox"/> Humane society/ rescue <input type="checkbox"/> Stray <input type="checkbox"/> Farm/outside <input type="checkbox"/> Don't know    Other:
Litter size (if known):	
Age when weaned (if known):	
If obtained as a kitten how was the kitten raised:	<input type="checkbox"/> Inside house <input type="checkbox"/> Outside only <input type="checkbox"/> Cattery <input type="checkbox"/> House & garage <input type="checkbox"/> Free run of house <input type="checkbox"/> Specific room <input type="checkbox"/> Don't know    Other:
Primary purpose for which kitten was	<input type="checkbox"/> Adult's pet <input type="checkbox"/> Family Pet <input type="checkbox"/> Children's pet

obtained:	<input type="checkbox"/> Show cat <input type="checkbox"/> Breeding <input type="checkbox"/> Farm/outside <input type="checkbox"/> Looks      Other:
If the cat was previously owned, for what primary purpose was the cat kept:	<input type="checkbox"/> Adult's pet <input type="checkbox"/> Family Pet <input type="checkbox"/> Children's pet <input type="checkbox"/> Show <input type="checkbox"/> Breeding <input type="checkbox"/> Farm/outside <input type="checkbox"/> Don't know <input type="checkbox"/> Research/ teaching      Other:
How did you select this particular cat:	<input type="checkbox"/> Breeder selected <input type="checkbox"/> No Choice <input type="checkbox"/> Most timid/shy <input type="checkbox"/> Most outgoing <input type="checkbox"/> Biggest <input type="checkbox"/> Assertive <input type="checkbox"/> Smallest <input type="checkbox"/> Submissive <input type="checkbox"/> Looks <input type="checkbox"/> N/A <input type="checkbox"/> Other:
Describe your cat's personality as a kitten:	To Owner: <input type="checkbox"/> Friendly <input type="checkbox"/> Aloof <input type="checkbox"/> Aggressive <input type="checkbox"/> Shy To Strangers: <input type="checkbox"/> Friendly <input type="checkbox"/> Aloof <input type="checkbox"/> Aggressive <input type="checkbox"/> Shy <input type="checkbox"/> Happy outgoing <input type="checkbox"/> Anxious <input type="checkbox"/> Inhibited <input type="checkbox"/> Submissive <input type="checkbox"/> Hyper-excitable <input type="checkbox"/> Fear of noises <input type="checkbox"/> Fearful of environment <input type="checkbox"/> Don't know Other:
Describe your cat's current personality:	To Owner: <input type="checkbox"/> Friendly <input type="checkbox"/> Aloof <input type="checkbox"/> Aggressive <input type="checkbox"/> Shy To Strangers: <input type="checkbox"/> Friendly <input type="checkbox"/> Aloof <input type="checkbox"/> Aggressive <input type="checkbox"/> Shy <input type="checkbox"/> Happy outgoing <input type="checkbox"/> Anxious <input type="checkbox"/> Inhibited <input type="checkbox"/> Submissive <input type="checkbox"/> Hyper-excitable <input type="checkbox"/> Fear of noises <input type="checkbox"/> Fearful of environment      Other:
Has your cat been bred?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
If bred how many litters?    Average litter size:	
How much interaction did the kitten have with people in the first year of life:	<input type="checkbox"/> Household members <input type="checkbox"/> Occasional guests <input type="checkbox"/> Frequent guests <input type="checkbox"/> Children < 6yrs <input type="checkbox"/> Children 7-11 yrs <input type="checkbox"/> Children >12 years <input type="checkbox"/> Veterinary clinic <input type="checkbox"/> Groomer <input type="checkbox"/> Don't know
What method of litter training was used:	
Your reaction to mistakes during house training:	
Was there any interaction with other kittens/cats, provide details:	
Did your cat attend kitten parties?	<input type="checkbox"/> Yes <input type="checkbox"/> No

## Current Members Dwelling in the Home

Please describe the home environment by listing the name of each family member living at home as well as frequent visitors. Please put a \*\* next to the primary caregiver

Name:	Family Relationship	Age:	Sex:	Occupation:	Describe how they get along with the cat:	Present at consult:


## Your Pets Environment

Please feel free to send pictures, diagrams and or videos to help us better understand the layout of your house, yard and your pets environment, including litter boxes, windows, doors, feeding areas.

What type of home do you have: ☐ Apartment ☐ House ☐ Condo ☐ Townhome  
 If other, provide details: ☐ Other Details:

What type of area do you live in: ☐ Urban ☐ Suburban ☐ Rural  
☐ Busy/lots of activity ☐ Quiet ☐ Moderate  
☐ Other Details:

What areas of your home does your cat have access to:

Do you have a backyard? ☐ Yes ☐ No

If yes, what type of fencing/containment do you use for your cat: ☐ Chain link /livestock ☐ Privacy ☐ Invisible fence  
☐ Outdoor kennel ☐ Other Height of fence:  
 Details:

## Other Household Pets

Have you owned cats previously? ☐ Yes ☐ No

Have you owned this breed of cat previously? ☐ Yes ☐ No

Have you owned other pets previously? ☐ Yes ☐ No

Please list ALL the animals in the household in the sequence they were obtained.

Please describe the nature of the cat's interaction with this pet (eg occasional growls, avoidance, plays)

Name	Age obtained	Age current	Weight	Species/ Breed	Spayed or Neutered	Interaction
					<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Yes <input type="checkbox"/> No	

## Medical History

Date of last veterinary visit	
What are the most recent set of vaccinations received and date, select all that apply:	<input type="checkbox"/> Rabies <input type="checkbox"/> 1yr <input type="checkbox"/> 3 yr    Date: <input type="checkbox"/> Rhino/Calici/Panleukopenia    Date: <input type="checkbox"/> Feline Leukemia    Date: <input type="checkbox"/> Feline Infectious Peritonitis    Date: <input type="checkbox"/> Feline Immunodeficiency Virus    Date: Other:    Date:
Date dewormed:	
Provide medical history (infection/surgeries) and prescribed treatment:	History:    Treatment: History:    Treatment: History:    Treatment: History:    Treatment:
Current/regular medications: (Such as allergy/heartworm/herbal/over the counter/pain medication/supplements/topical flea and tick, etc.)    Route administered= oral, topical, eyes, ears, etc.	
Medication:    Dose:	Route:    Frequency given:
Medication:    Dose:	Route:    Frequency given:
Medication:    Dose:	Route:    Frequency given:
Medication:    Dose:	Route:    Frequency given:
Medication:    Dose:	Route:    Frequency given:
Has there been any change in:    Drinking- Eating-	<input type="checkbox"/> Yes <input type="checkbox"/> No    Details: <input type="checkbox"/> Yes <input type="checkbox"/> No    Details:
Have you noticed any of the following:	<input type="checkbox"/> Coughing <input type="checkbox"/> Sneezing <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Hairballs
Has your cat ever been treated for their behavior in the past? If so, describe treatment and medication (if applicable):	<input type="checkbox"/> Yes <input type="checkbox"/> No    If so, describe treatment: Medications:    Dose: Medications:    Dose: Medications:    Dose: Medications:    Dose:
Does your pet have or ever had any seizures:	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Diet and Feeding Habits</b>	
Type(s) of Food: % of each Brand(s): (i.e.: Purina, Friskies, Eukanuba...)	Dry:    Can:    Table scraps: Special meal:    Brand(s):
Who is primarily responsible for the feeding:	Name:
How much food is given: What is the approximate time(s) of day :	How much food: Time of Day:
Feeding schedule is: Describe the feeding process:	<input type="checkbox"/> Consistent <input type="checkbox"/> Varies
Where is the cat fed (physical location):	
Where is the cat fed in relation to other cats/ pets in the household:	
Is the cat protective of their food (growl, snap, hiss swat, or bite)?    If so, provide details:	<input type="checkbox"/> Yes <input type="checkbox"/> No Details:
Describe your cat's appetite: What speed do they typically eat at:	<input type="checkbox"/> Good <input type="checkbox"/> Average <input type="checkbox"/> Poor <input type="checkbox"/> Fast <input type="checkbox"/> Slow
Do you have to be present for your cat to eat?	<input type="checkbox"/> Yes <input type="checkbox"/> No

What are your cats favorite foods:	
Do you give your cats treats? If yes, is it contingent on behavior? If yes, describe how treats are used:	<input type="checkbox"/> Yes <input type="checkbox"/> No   Types of treats: <input type="checkbox"/> Yes <input type="checkbox"/> No How treats are used:
How much does your cat drink in a day (in pints or liters):   How many water bowls are provided:	
Do you add any supplements to their diet? If so, provide details:	<input type="checkbox"/> Yes <input type="checkbox"/> No Details:
How many litter boxes are there?	

Location of litter boxes:	<input type="checkbox"/> Living area <input type="checkbox"/> Spare room <input type="checkbox"/> Basement <input type="checkbox"/> Kitchen <input type="checkbox"/> Laundry room <input type="checkbox"/> Hallway <input type="checkbox"/> Bathroom <input type="checkbox"/> Closet <input type="checkbox"/> Other   Details:
Type of litter box:	<input type="checkbox"/> Open <input type="checkbox"/> Automatic/self cleaning <input type="checkbox"/> Covered ( <input type="checkbox"/> top; <input type="checkbox"/> front entrance) <input type="checkbox"/> Other   Dimensions:
Type of litter:	<input type="checkbox"/> Clumping <input type="checkbox"/> Shavings <input type="checkbox"/> Sand <input type="checkbox"/> Clay <input type="checkbox"/> Crystals <input type="checkbox"/> Newspaper ( <input type="checkbox"/> Pelleted, <input type="checkbox"/> Shredded) <input type="checkbox"/> Wheat or corn based <input type="checkbox"/> Deodorized <input type="checkbox"/> Scented <input type="checkbox"/> Unscented <input type="checkbox"/> Consistent <input type="checkbox"/> Varies <input type="checkbox"/> Liners used ( <input type="checkbox"/> Yes <input type="checkbox"/> No; <input type="checkbox"/> Always <input type="checkbox"/> Varies) <input type="checkbox"/> Other   Details:
Litter box maintenance:	Scooped: <input type="checkbox"/> < 1x/week <input type="checkbox"/> weekly <input type="checkbox"/> several times/week <input type="checkbox"/> daily <input type="checkbox"/> >1x/day <input type="checkbox"/> Other <input type="checkbox"/> Consistent <input type="checkbox"/> Varies Details: Washed: <input type="checkbox"/> < 1x/week <input type="checkbox"/> weekly <input type="checkbox"/> several times/week <input type="checkbox"/> daily <input type="checkbox"/> monthly <input type="checkbox"/> Other <input type="checkbox"/> Consistent <input type="checkbox"/> Varies Products used to wash: Completely emptied: <input type="checkbox"/> >1x/week <input type="checkbox"/> weekly <input type="checkbox"/> monthly <input type="checkbox"/> yearly <input type="checkbox"/> never
Litter box habits:	Cat scratches litter before ( <input type="checkbox"/> Yes <input type="checkbox"/> No) & after elimination ( <input type="checkbox"/> Yes <input type="checkbox"/> No) Cat covers feces: <input type="checkbox"/> Yes <input type="checkbox"/> No   Other: Cat puts all four feet in box: <input type="checkbox"/> Yes <input type="checkbox"/> No If no, describe which feet are out and where they are placed: Does your cat vocalize when eliminating? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is it during: Urination: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes <input type="checkbox"/> Always; Bowel movements: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes <input type="checkbox"/> Always; Describe any other unusual litter box habits:
Elimination outside of the box.	<input type="checkbox"/> Yes <input type="checkbox"/> No . If yes, Please draw a diagram of your house showing the locations of litter boxes, sleeping areas (humans and pets), feeding areas, water bowls, doors and windows as well as placed the cat has eliminated.

## Daily Activities

Where does your cat sleep:	
When does your cat get up in the morning:	
Does your pet ever wake you at night? If yes, how often and any idea why:	<input type="checkbox"/> Yes <input type="checkbox"/> No How often:
Does your cat get to go outside? If so how long do they like to stay out:	<input type="checkbox"/> Yes <input type="checkbox"/> No How long:
How does your cat ask to go outside:	
Does your cat roam free in the yard:	<input type="checkbox"/> Yes <input type="checkbox"/> No

What type of exercise does your cat receive: If other, provide details:	<input type="checkbox"/> Walk <input type="checkbox"/> Fetch <input type="checkbox"/> Laser <input type="checkbox"/> Food puzzles Details:
Exercise schedule including average hour/day	<input type="checkbox"/> < 1/week <input type="checkbox"/> once/day <input type="checkbox"/> twice/day <input type="checkbox"/> 3x/day <input type="checkbox"/> several times/week <input type="checkbox"/> >3x/day <input type="checkbox"/> Other <input type="checkbox"/> Consistent <input type="checkbox"/> Varies    Details:
Is there any specific time devoted to play or training on a daily basis:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your cat play games with you or other family members? If yes, provide details:	<input type="checkbox"/> Yes <input type="checkbox"/> No Details:
Who initiates play:	<input type="checkbox"/> Cat <input type="checkbox"/> People
What types of toys does your cat play with: If other, provide details:	<input type="checkbox"/> Balls <input type="checkbox"/> Squeaky toys <input type="checkbox"/> Crinkle toys <input type="checkbox"/> Fake mice <input type="checkbox"/> Catnip <input type="checkbox"/> Feather toys <input type="checkbox"/> Other    Details:
Where does your cat stay during the day when no one is home:	<input type="checkbox"/> Cage <input type="checkbox"/> Specified Room <input type="checkbox"/> Free Run (in house) <input type="checkbox"/> Free Run (fenced yard) <input type="checkbox"/> Outside cage <input type="checkbox"/> Basement <input type="checkbox"/> Garage <input type="checkbox"/> Other    Describe:
Typically, how long is your cat left alone without people on any given day: Consistent or varied?	<input type="checkbox"/> Consistent <input type="checkbox"/> Varies
Does your cat ever engage in the following behaviors while you are gone?  If so, is it every time you are gone? Have you ever videotaped your cat while gone?	<input type="checkbox"/> Vocalize <input type="checkbox"/> Destructive behaviors <input type="checkbox"/> Urinate (outside of the litter box) <input type="checkbox"/> Defecate (outside of the litter box) <input type="checkbox"/> Self licking/chewing <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
What does your cat do when you arrive at home?	Details:
What does your cat do during family meals:	
Has there been any change in your household routine (new baby, new work hours...)? If yes, provide details:	<input type="checkbox"/> Yes <input type="checkbox"/> No Details:
List 5 things your cat likes the most (activities, food, toys...)	

## Training

How would you rate your cats learning ability:    ☐ Poor    ☐ Fair    ☐ Average    ☐ Excellent

Please describe any training that you or someone else has done with your cat:

Does your cat know any tricks:

How do you correct your cat when he/she misbehaves:

## Type of Discipline Used

Type of discipline	Describe method	Situations that method is used	Pet's Response	Improves behavior	Behavior is
None ever				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing

				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> The same <input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing
Verbal reprimand				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing <input type="checkbox"/> The same
Distraction				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing <input type="checkbox"/> The same
Redirection				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing <input type="checkbox"/> The same
Startling				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing <input type="checkbox"/> The same
Physical				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing <input type="checkbox"/> The same
Shock				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing <input type="checkbox"/> The same
Time out				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing <input type="checkbox"/> The same
Shake down or scruff				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing <input type="checkbox"/> The same
Roll over				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing <input type="checkbox"/> The same
Water				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing <input type="checkbox"/> The same
Noise can or Air can				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing <input type="checkbox"/> The same
Other				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing <input type="checkbox"/> The same

## Interaction With Family Members

Reaction to handling – Is there any aggression in the following circumstances? This can include growling, hissing, lunging, slapping, showing teeth, or even biting. If biting please describe the injury.

Fill out the following tables depicting your feline's typical reaction:

In each box, , describe the typical type of aggression (growling, hissing, slapping, biting, etc) shown

	Aggression	Aggression is directed at: (include all individuals and circumstances)	If not aggressive, what does your pet do in these situations
Hugging	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Reaching over / petting head	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Petting cat elsewhere	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Disturbed when resting	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Disciplining	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Taking food away	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Taking other objects	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Grooming/Brushing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Nail trimming	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Bathing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Grasping collar or restraining	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Roughhousing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Lifting the cat up	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Physical punishment	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Taking on/off collar	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Staring at cat	<input type="checkbox"/> Yes <input type="checkbox"/> No		

## Interaction With Others

How does your cat behave when visitors come to the house (i.e. –Hiding, hissing, door charging): How do you respond?	
Is the behavior different towards <b>familiar</b> and <b>unfamiliar</b> people? If yes, provide details:	<input type="checkbox"/> Yes <input type="checkbox"/> No Details:
Does your cat display aggression (growling, hissing, slapping, biting) to visitors <b>inside</b> your home? If yes, provide details:	<input type="checkbox"/> Yes <input type="checkbox"/> No Details:
Has your cat ever bitten or attacked anyone? If yes, how many:	<input type="checkbox"/> Yes <input type="checkbox"/> No Details:
What is your cat's response to: Frequent visitors: Occasional visitors: Rare visitors:	Frequent: Occasional: Rare:

## Describe your pet's reaction in the following situations

Familiar men	Details:
Familiar women	Details:
Familiar babies	Details:
Familiar children, 1-6 yrs old	Details:
Familiar children, 7-11 yrs old	Details:
Familiar children 12-18 yrs old	Details:
Unfamiliar babies	Details:
Unfam children, 1-6 yrs old	Details:
Unfam children, 7-11 yrs old	Details:
Unfam children, 12-18 yrs old	Details:
Other animals (cats, dogs, birds)	Details:
Crowds/busy areas	Details:
Unfamiliar cats on property	Details:



Carrier or crate	Details:
Riding in the car	Details:
Vacuum cleaner and/or broom	Details:
Thunder and or loud noises	Details:

### Behavior at pet care facilities

Veterinary office	<input type="checkbox"/> Happy to greet everyone, friendly <input type="checkbox"/> Cowers, fearful <input type="checkbox"/> Aggressive with restraint <input type="checkbox"/> Needs to be muzzled	<input type="checkbox"/> Neutral <input type="checkbox"/> Fine <input type="checkbox"/> Struggles to get away/escape <input type="checkbox"/> Aggressive as soon as approached <input type="checkbox"/> Needs to be sedated <input type="checkbox"/> Other
Groomers	<input type="checkbox"/> Happy to greet everyone, friendly <input type="checkbox"/> Cowers, fearful <input type="checkbox"/> Aggressive with restraint <input type="checkbox"/> Needs to be muzzled	<input type="checkbox"/> Neutral <input type="checkbox"/> Fine <input type="checkbox"/> Struggles to get away/escape <input type="checkbox"/> Aggressive as soon as approached <input type="checkbox"/> Needs to be sedated <input type="checkbox"/> Other <input type="checkbox"/> N/A
Boarding Facility	<input type="checkbox"/> Happy to greet everyone, friendly <input type="checkbox"/> Cowers, fearful <input type="checkbox"/> Aggressive with restraint <input type="checkbox"/> Needs to be muzzled	<input type="checkbox"/> Neutral <input type="checkbox"/> Fine <input type="checkbox"/> Struggles to get away/escape <input type="checkbox"/> Aggressive as soon as approached <input type="checkbox"/> Needs to be sedated <input type="checkbox"/> Other <input type="checkbox"/> N/A

### Bite History

Has your cat ever bitten:	Who / Name	What part of body	Did it break the skin	Severity	Trigger (what instigated the bite)
Person <input type="checkbox"/> Yes <input type="checkbox"/> No		Details:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Details:	Details:
Another cat <input type="checkbox"/> Yes <input type="checkbox"/> No		Details:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Details:	Details:
Household pet <input type="checkbox"/> Yes <input type="checkbox"/> No		Details:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Details:	Details:
Other animal <input type="checkbox"/> Yes <input type="checkbox"/> No		Details:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Details:	Details:
Other <input type="checkbox"/> Yes <input type="checkbox"/> No		Details:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Details:	Details:
Is there legal action pending due to your cat's aggressive behavior?					<input type="checkbox"/> Yes <input type="checkbox"/> No
When does your cat's rabies vaccine expire?					

### The Current Problems

Presenting problems (in order of importance)	Goals and acceptable outcomes

### Problem History

Primary problem to be addressed	
Is this a chronic (constant) or intermittent problem:	<input type="checkbox"/> Chronic <input type="checkbox"/> Intermittent
Where does the problem commonly occur:	
Who is present:	

How often:	
When was the first incident?	
Where there any changes at that time?	
If house soiling, does it occur when you're:	<input type="checkbox"/> Home <input type="checkbox"/> Away <input type="checkbox"/> Both
If destructive, does it occur when you're:	<input type="checkbox"/> Home <input type="checkbox"/> Away <input type="checkbox"/> Both
What triggers the incident?	
Additional details surrounding the problem:	
What was the cat's reaction to your response:	
Was there any punishment? If so, what:	<input type="checkbox"/> Yes <input type="checkbox"/> No Punishment:
Was there a bite wound:	<input type="checkbox"/> Puncture <input type="checkbox"/> Tear <input type="checkbox"/> Other
Prior to this incident, describe the previous three incidents:	1 2 3
How frequently does this type of incident occur:	<input type="checkbox"/> Multiple times a day <input type="checkbox"/> Daily <input type="checkbox"/> Several times a week <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly Other:
Does this problem occur when left alone:	<input type="checkbox"/> Always <input type="checkbox"/> Sometimes <input type="checkbox"/> Never
Does this problem occur when family members are present:	<input type="checkbox"/> Always <input type="checkbox"/> Sometimes <input type="checkbox"/> Never
What has been done to correct the problem:	
Is the problem getting:	<input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> No Change
Do you suspect any cause:	
Previous treatment (s):	
After previous treatment the behavior was:	<input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> No Change; Details:
Were medications or natural remedies used?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Name of medications/ remedies used (to alter behavior)	Dose	How long used	Effect	Side effects

## Relationship with Feline

How would you describe your/ family's relationship with this cat:	
What are your/family's feelings about the cat's present behavior:	
What is your expectation for change:	
How would you describe the severity of this problem?	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Have you considered removing your pet from the home if the problem cannot be improved?	<input type="checkbox"/> Yes <input type="checkbox"/> No Comment:
Under what circumstances would you consider relinquishing the cat to a shelter or rescue:	
Have you considered euthanasia?	<input type="checkbox"/> Yes <input type="checkbox"/> No Comment:

What are acceptable outcomes following behavior treatment if the pet cannot be “cured”?	
Please list any other information that you think might be helpful in the diagnosis of your pet.	
How do you learn best?	

### Please check the statements that best describe how you are feeling

I am here out of curiosity; the problem is not serious.	<input type="checkbox"/>
I would like to change the problem, but it is not serious.	<input type="checkbox"/>
The problem is serious and I would like to change it; if it remains unchanged that's all right.	<input type="checkbox"/>
The problem is serious and I would like to change it; if it remains unchanged I will keep my cat.	<input type="checkbox"/>
The problem is serious and I would like to change it; if it remains unchanged I will euthanize my cat or give him/her up.	<input type="checkbox"/>

### Please check the statements that best describe how you feel about using medication to treat your pet

I wish to use <b>behavior modification alone</b> to improve my pet's behavior.	<input type="checkbox"/>
I wish to use behavior modification alone but <b>will consider using medication</b> if it is recommended.	<input type="checkbox"/>
I wish to use <b>a combination</b> of behavior modification and medications to improve my pet's problem.	<input type="checkbox"/>
I wish to use a combination of <b>behavior modification and natural supplements</b> to improve my pet's behavior problem.	<input type="checkbox"/>
I fully anticipate using <b>medications</b> to improve my pet's problem.	<input type="checkbox"/>
I am concerned about using medication or behavior modification because:	

### Other Problems

Urine Marking	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diarrhea/ vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No	House soiling	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nervous/anxious	<input type="checkbox"/> Yes <input type="checkbox"/> No	Meowing/howling/ crying	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rolling in unsavory items	<input type="checkbox"/> Yes <input type="checkbox"/> No
Demands attention	<input type="checkbox"/> Yes <input type="checkbox"/> No	Demands touch	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jumps up on people	<input type="checkbox"/> Yes <input type="checkbox"/> No
Wants own way	<input type="checkbox"/> Yes <input type="checkbox"/> No	Aggressive to owners	<input type="checkbox"/> Yes <input type="checkbox"/> No	Aggressive to strangers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Aggr. to cats in household	<input type="checkbox"/> Yes <input type="checkbox"/> No	Aggr. to strange cats	<input type="checkbox"/> Yes <input type="checkbox"/> No	Aggr. to other animals	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anorexia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chewing objects	<input type="checkbox"/> Yes <input type="checkbox"/> No	Coprophagia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Compulsive eating	<input type="checkbox"/> Yes <input type="checkbox"/> No	Compulsive drinking	<input type="checkbox"/> Yes <input type="checkbox"/> No	Eating Grass/ Plants	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pica	<input type="checkbox"/> Yes <input type="checkbox"/> No	Eating garbage	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prey catching	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stealing food	<input type="checkbox"/> Yes <input type="checkbox"/> No	Light/shadow chasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Depressed inappetent	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fly snapping	<input type="checkbox"/> Yes <input type="checkbox"/> No	Air/mouth licking	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scratching self	<input type="checkbox"/> Yes <input type="checkbox"/> No
Licking self	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sucking on self	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chewing on self	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cannibalism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Checking hind end	<input type="checkbox"/> Yes <input type="checkbox"/> No	False pregnancy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Masturbation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mounting people	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mounting animals	<input type="checkbox"/> Yes <input type="checkbox"/> No
Self nursing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Circling/whirling	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tail biting	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hyper reactive	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacing, figure 8s	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lameness/cond.	<input type="checkbox"/> Yes <input type="checkbox"/> No

Digging	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scratching objects	<input type="checkbox"/> Yes <input type="checkbox"/> No	Freezing	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fear of thunder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fear of people	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fear of situations	<input type="checkbox"/> Yes <input type="checkbox"/> No

Thank you for filling this questionnaire out.

Please download the “Preparing for your consult form” and the “Release form.”

If there is any other information that you feel will help me diagnose and treat your pet please feel free to elaborate.

By completing the questionnaire, reading and signing below you are authorizing us to evaluate, determine a treatment plan for your pet. A written copy of the discharge instructions will be given to you and a summary to your veterinarian. You are encouraged to adhere to the recommendations. If you do not understand the instructions, or are having difficulty implementing or complying with them, please notify us so you can be given appropriate instructions in how to proceed. Your appointment includes three months of follow up via email or phone calls.

Videos and photos may be taken during the consult.

- Any videos or photos taken become part the record and may be used anonymously for teaching, including staff, students, other veterinary personnel or clients as well as research.

The doctor may recommend that your pet be treated with medication.

- Should medication be prescribed it is because that particular medication has been considered to be the most effective for your pet's condition.
- Many of the medications are not labeled (extra-label use) for treatment of behavior problems in pets but have been successfully used to treat these conditions in many pets by many veterinarians and board certified veterinary behaviorists. This does not mean that the medication is dangerous or harmful to your pet, only that they were not the subjects tested for approved use.
- All medications have the potential for side effects. The side effects for the medicine will be explained during the consult and documented on your discharge instructions. If you are ever concerned please contact the clinic.

If your pet is aggressive you should be aware of the following:

- Any animal that is aggressive can do serious harm, which may cause injury, including fatal injuries to other animals, family members, and other people. Treatment for aggressive behavior is not a guarantee that the aggression will be controlled, as it is impossible to ensure that all management and safety instructions will be strictly adhered to at all times.
- There are responsibilities with owning an animal, including the responsibility or potential liability for any damage the pet does to people or property. The responsibility is not changed or transferred by seeking behavioral help.

Some behavior problems are pathological, including some forms of aggression. These problems, while never cured, can be treated and managed effectively so that the pet and family have a good quality of life. Euthanasia may result if the problems are not treated or managed appropriately. The purpose of this appointment is to avoid euthanasia if possible and help the pet to live a long, healthy, happy life.

I have read and understand all the information presented above. ☐ Yes ☐ No

If you have any questions or concerns please contact us.

Name of person responsible for the pet:

Signature:

Date:

Please bring the signed form to the appointment to expedite check in or return it with your behavior questionnaire.

Thank you for taking the time to complete all of the forms.

\* Release form adapted from K. Overall and S. Crowell-Davis