Behavioral Medicine Clinic

The Ohio State University Veterinary Medical Center
601 Vernon L. Tharp St., Columbus, OH 43210
Main phone: **614-292-3551** Direct phone: **614-292-4655**
Email: ***OSUVET.BehaviorMedicine@osu.edu***

RETURNING VISIT BEHAVIOR QUESTIONNAIRE FOR DOGS

Please complete this form and return it by email at least 3 days before your appointment.
The return of this form is a ***CRUCIAL*** *part of your pet's recheck appointment.*

Date/Time of appointment:

Patient Information:
Pet's name:
Breed: Color:
Age: Date of birth:
Sex: Neutered/Spayed? Y / N

Owner Info:
Last name: First name:
Street address:
City, State, ZIP:
Preferred phone: Secondary phone:
Email:

Additional contacts:
Last name: First name:
Preferred phone: Secondary phone:
Email:

Current Veterinarian Information:
Dr.
Clinic Name:
Street address:
City, State, ZIP:
Phone:
Fax:
Email:

Current Pharmacy Information:
Name:
Phone:

Please have your pet's veterinary records for any visits since your last appointment with us submitted via online portal or emailed to OSUVET.BehaviorMedicine@osu.edu.

What are your goals for this recheck consultation? Please be specific.

BEHAVIORAL CONCERNS

Please list your pet's current issues and indicate whether they are pre-existing or new since your last visit. For pre-existing issues, please note what changes there have been. For new issues, please note when the behavior started and the severity of the problem.

PRE-EXISTING PROBLEM	WORSE	IMPROVEMENT IN INTENSITY				IMPROVEMENT IN FREQUENCY			
		<25%	25% - 50%	50% - 75%	75% - 95%	<25%	25% - 50%	50% - 75%	75% - 95%

NEW PROBLEM DESCRIPTION	DATE BEGAN	SEVERITY		
		NOT SERIOUS	FAIRLY SERIOUS	VERY SERIOUS

Please give us detailed description(s) of recent representative events of each *current* problem. Include the location, dog's body postures, any people present, any triggers, your reaction, and the outcome.

DATE	INCIDENT
DATE	**INCIDENT**
DATE	**INCIDENT**
DATE	**INCIDENT**

CHANGES TO HOUSEHOLD

Please tell us if there have been any changes in your household since your last appointment**. If any of these are upcoming, please explain in details section**

CHANGE	Y	N	Details
Arrival of new household member (please list name)			
Departure or death of a household member (please list name)			
Moved to new home			
Schedule change (gained/lost job, school, etc.)			
Pet added (list name and information)			
Death or relinquishment of other pet (list name and information)			
Other (please explain)			

BEHAVIOR MEDICATIONS

Please complete the table below in regard to your pet's current medications, dosages, and apparent effectiveness.

MEDICATION	DOSE (the mg strength)	FREQUENCY (how often you give it)	RESPONSE					SIDE EFFECTS (if any)
			WORSE	BETTER				
				<25%	25%-50%	50%-75%	70%-95%	

MEDICAL HISTORY

Please list any newly diagnosed medical problems and how they were treated.

DATE	DIAGNOSIS	**TREATMENT** (including medications and dosage)	OUTCOME

TRAINING

1. Is your dog attending a training class or do you have a trainer come to your home? ☐ Yes ☐ No
   If so, please give details, including name of trainer or facility:

2. What method of training is being utilized (i.e. clicker training, leash corrections, special collars, etc.):

3. Are you feeling successful with this training?

BITE HISTORY

1. Has your pet bitten since your last visit?

2. Please list the number of bites that broke skin:

3. Please list the number of bites reported to public health authorities, and to whom: (i.e. local authorities, hospital, humane society, etc.):

CURRENT STATUS

1. Have you recently considered finding another home for this pet?
   ☐ Yes ☐ No

2. Have you recently considered euthanasia (putting your dog to sleep)?
   ☐ Yes ☐ No

3. Has someone recently recommended you euthanize your pet?
   ☐ Yes ☐ No

Has the behavioral medicine clinic helped you with your pet?

What else would you like us to know about your pet and his/her current situation?