

NeW Training Client Information Form

OWNER INFORMATION

Pet Parent #1

Full Name: _____

Phone Number: _____

Address: _____

Email: _____

Pet Parent #2

Full Name: _____

Phone Number: _____

Address: _____

Email: _____

Permission to use photos or videos for business related content (initial here): _____

How do you hear allergies?

Website Social Media Family/Friend Other: _____

EMERGENCY CONTACT INFORMATION

Full Name: _____

Phone Number: _____

Address: _____

Relationship: _____

City: _____

Zip: _____

DOG BACKGROUND

About

Name: _____

Breed: _____

Gender: M F Colors/Special Markings: _____

Birthday: _____

Age: _____

Spayed/Neutered: _____

Where did you get your pet? Breeder Friend Shelter

How did you have your pet? _____

Your Pet's Health History

Veterinarian Name: _____

Phone Number: _____

Email: _____

Does your pet take any medications? Yes No

Please list past / current medications & health conditions: _____

Please list any additional concerns: _____

Does your pet have any allergies? Yes No

Please list: _____



NeW Training Client Information Form

Diet and Nutrition

Weight Loss Food? Very

Brand:

Amount and how often:

Treats? Yes No

Brand:

Amount and how often:

Accidents? Yes No In frequent accidents?

Pee Pad trained? Yes No

How often does your dog go out?

Exercise

How often is exercise provided for? _____

What type of exercise do you provide? _____

Major equipment used:

Leash Harness Halt Strobe Collar Leash Flap collar

Prong Collar Shock Collar Electronic Fence

Other: _____

Behavioral and Social Interactions

Check all that apply:

Bumps on people Aggressive with people Aggressive with animals Fearful

Mouthing/Nipping Urinates/Defecates in the house Toy Possessive Anxious

Food Possessive Counter Surfs Excessive barking Chews on furniture/property

Steals Objects/Trash Coprophagia (eats stool) Pulls on Leash Door Dashes

Destructive when alone or in car Hides Least favorite Hisses

Responsive to other people Responsive to other dogs Other _____

How would you describe your pet's energy? High Medium Low

Other: _____

Has your pet ever bitten anyone or an animal? Yes No

If yes, please explain the circumstances: _____

Has your pet been socialized with other animals? Yes No

If so, how do they interact? _____



NeW Training Client Information Form

Training Name: **AMBERS**

Previous training:

Trained courses: Group class Private lessons Board & train None

Training facility Name or Trainer Name: _____

Which commands does your pet know?

Sit Wait/Stay Leave It Leash Walking Crate Trained Go To Mat

Drop Stand Other: _____

Training method? **PLAYGROUND**

Food/treats Praise Verbal Corrections Physical Corrections Toys

Commands you would like to work on in order of importance:

Environment / Lifestyle: **AMBERS**

List all the people including yourself, that live in your household - name, age, and relationship

List all the pets that live in your household - name, species, gender, age and spayed/neutered **PLAYGROUND**

Does your pet get along with the other household pets? Yes No

Have you owned a dog in the past? Yes No

Type of home: House Townhome Apartment Other: _____

Fenced yard: Yes No

Where is your pet kept when alone?

• Ö • u • i • u j • E • j • u • ñ • Bun Y

AMBERS

How many hours a day is your pet without human companionship?

Where does your pet sleep at night?

PLAYGROUND

