Veterinary Form

Client Name: _____ Client Phone: _____

Pet Name: _____ Age: _____

Breed: _____ Sex: _____ Body Weight: _____

Diagnosis and Observations: _____

_____

_____

Treatment/Surgical Procedure(s): _____

Date of Treatment / Condition Onset: _____

Approved therapy "start date": _____

Medications/Supplements: _____

_____

Precautions/Restrictions: _____

_____

Desired Focus/Outcome: _____

_____

Patient's Prescribed Program:

☐ Aquatic Therapy (assumed) ☐ Targeted Pulsed Electromagnetic Field Therapy (tPEMF)

☐ Stretching / Range of Motion ☐ Owner Education and instruction

Veterinarian/Surgeon: _____

Veterinary Hospital: _____

Phone: _____ Fax: _____ Email: _____

DVM Signature: _____ Date: _____

Please complete this form and email or fax back to: 408-353-6545

P.O. Box 1025, Los Gatos, CA 95031 phone: 408-472-6631 email: AquaDogK9pt@yahoo.com