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Please print this form and bring it with you at the time of your appointment

Pet's Name: _____

Pet's Breed: _____ Age: _____ Sex: M F

Approximate Weight: _____ Canine Feline Other: _____

Client Information

Last Name: _____ First Name: _____

Telephone Number: (____) _____

Address: _____

City State Zip _____

Referring DVM /Practice Information

Referring DVM: _____

Clinic Name: _____

Clinic Address: _____

Phone: _____ Fax: _____

Primary Veterinary Diagnosis: _____

Prognosis Offered: _____

Current Preferred Treatment: Chiropractic

Treatment to Date: _____

Medications: _____

The following are enclosed:

Radiographs Radiographic Report (s) Laboratory Results

Advanced Imaging Advanced Imaging Report(s)

Clients MUST provide evidence of current rabies vaccination

Rabies vaccination date: _____