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**CANADA WEST**  
 VETERINARY SPECIALISTS

**PET OWNER FORM**

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# Neurology Consultation Questionnaire

OWNER NAME: First: \_\_\_\_\_ Last: \_\_\_\_\_

Mr.  Mrs.  
 Ms.  Dr.

PET'S NAME: \_\_\_\_\_

Please provide only a one or two word answer OR just tick the appropriate box.

1 When was he or she last normal? \_\_\_\_\_

2 What was the first sign that you noted? \_\_\_\_\_

3 Has your pet had any known exposure to bats?  Yes  No

4 Rabies vaccine current?  Yes  No

5 Any travel to Van Island or outside of BC?  Yes  No

If YES, please specify: \_\_\_\_\_

6 Has your pet had any diarrhea or vomiting in the last month?  Yes  No

7 Has your pet had any coughing or sneezing in the last month?  Yes  No

8 Has your pet shown any compulsive circling?  Yes  No

9 Has your pet shown any compulsive pacing?  Yes  No

10 Has your pet shown any change in behaviour?  Yes  No

11 Has your pet shown any change in temperament?  Yes  No

12 Has your pet had trouble recognizing someone familiar?  Yes  No

13 Has your pet started urinating in inappropriate places?  Yes  No

14 Has your pet started defecating in inappropriate places?  Yes  No

15 Has your pet been staring vacantly at the walls?  Yes  No

16 Has your pet been pressing his or her head into a corner?  Yes  No

17 Has your pet been bumping into things as if they could not see?  Yes  No

18 Has your pet had any seizures?  Yes  No

19 Has your pet had any collapsing episodes?  Yes  No

20 Has your pet had any loss of balance?  Yes  No

21 Is your pet taking any medications at the moment?  Yes  No

22 Is your pet eating and drinking normally?  Yes  No

23 Has your pet had any other major illnesses or injuries?  Yes  No

If YES, please specify: \_\_\_\_\_

24 How old was your pet when you first acquired him or her? \_\_\_\_\_

25 Has your pet recently received aspirin (acetylsalicylic acid)?  Yes  No

If YES, please specify the dose and time received: \_\_\_\_\_

26 Do you have any other comments? \_\_\_\_\_