Abbey Animal Hospital
1949 Lynnhaven Parkway
Virginia Beach, VA 23453
(757) 471-1003

Feline Behavioral History Form

The information you provide here aids in the diagnosis and treatment of your cat's behavior problem. Please fill out the form completely and accurately. Circle or check all areas where given. You may use a separate sheet of paper if needed.

Part 1: Data:

Last Name_____ First Name_____ Today's Date _____

Pet's Name_____ Pet's Age _____

How did you hear of Abbey Animal Hospital? _____

Breed_____ Birth date:_____

Age obtained_____ Sex: Male Female Pregnant? Yes / No

Spayed/Neutered? Yes / No If yes, at what age: _____ Weight _____ Overweight?

Where did you obtain this pet: Breeder, Friend, Pet Store, Humane Shelter, Rescue, Other

Behavior Problems of parents or littermates, if known: _____

Your primary veterinarian's name: _____

Name of Clinic or Hospital _____

Office Phone: _____

Part 2: Principal Behavioral Complaint

Summarize the primary behavior problem in one sentence:

_____

_____.

How would you describe the severity of this problem? Mild Moderate Severe

Have you considered euthanasia? Yes / No Please Comment: _____

Describe the last two incidents in as much detail as possible. Include an approximate date of each incident:

1._____
_____
_____
_____
_____
_____
_____.

2._____
_____
_____
_____
_____
_____
_____.

FREQUENCY

Please indicate the number of times the problem has occurred in each of the times indicated below:

	PAST WEEK	PAST MONTH	PAST YEAR	Since you've owned
# of times				

BACKGROUND INFORMATION

At what age was your pet when the problem began?	
Were there any changes in the home at that time?	
List techniques you have used to correct the problem	1. 2. 3. 4. 5.

TECHNIQUES

What techniques (if any) have helped?	
What techniques have made the problem worse?	
Have any drugs been tried for this problem? If yes, what?	
What do you think is the reason for your cat's problem?	

PART 3: Home Environment

PERONS LIVING IN THE HOUSEHOLD

List each person living in the household, including age, sex, time away from home (example 9am-5pm), and comments on that person's relationship with your pet (for exam: "feeds cat" or "is afraid of cat")

NAME	AGE	SEX	HOURS AWAY	RELATIONSHIP W/ Pet

PETS LIVING IN THE HOUSEHOLD

List all other pets in the household. Comment on the relationship between the cat with the behavior problem and your other pets (for example: "get along" or "dominates cat.")

NAME	SPECIES	BREED	AGE	SEX	COMMENTS

DIET

FOOD/TREAT	**BRAND NAME**	**HOW OFTEN GIVEN?**	**DESIRE FOR THIS TYPE OF FOOD?**
WET CAT FOOD (canned)			Mild Moderate Strong
DRY CAT FOOD			Mild Moderate Strong
ADDITIONAL CAT FOOD			Mild Moderate Strong
TABLE SCRAPS / PEOPLE FOOD			Mild Moderate Strong
TREATS TYPE 1			Mild Moderate Strong
TREATS TYPE 2			Mild Moderate Strong
SUPPLEMENTS / VITAMINS			Mild Moderate Strong

LOCATION/ACTIVITY/EXERCISE

SITUATION	AMOUNT OF TIME per DAY or PER WEEK CAT SPENDS at this Site/Activity	INDICATE LOCATION (loose in house, in kitchen, in crate or pen, at park, ect.)	INDICATE WHAT CAT WEARS (nothing, collar, harness, chock chain, prong collar, halter, ect.)
In HOUSE, PER DAY			
OUTSIDE PER DAY			
ALONE PER DAY			
PLAYTIME, per day			
ASLEEP			

What is your pet's favorite toy?_____
What is your pet's favorite game? _____

PART 4: Behavioral Profile

Are you able to medicate your cat yourself? YES NO

What is the best way for you to give your cat medication? _____
_____

HANDLING

Check how your cat responds to the following tasks:

TASK	NO REACTION	AVOIDS	RESISTS	GROWLS, BITES	FAVORS, PURRS	COMMENTS
Nail Trim						
Greeting you						
Greeting Stranger						
Bathing						
Petting, Stroking						
Grooming						
Being Picked Up						

CORRECTIONS

Indicate any correction techniques you have used and indicate their effects on your cat's behavior.

TYPE of Correction	Have you Tried?	Improved the Problem	No Effect on the Problem	Made the problem worse
Time Out	Yes or No			
Water Sprayer	Yes or No			
Verbal Scolding	Yes or No			
Noisemaker Shaker can/siren	Yes or No			
Lifting by Scruff	Yes or No			
Spanking	Yes or No			
Other (describe)	Yes or No			

Please Describe other:_____
_____
_____
_____.

HOUSE SOILING

Are you having a house-soiling problem with your cat? YES NO
If you answered NO, please skip this section and continue on to AGGRESSION

Is the house-soiling problem related to: URINE FECES BOTH
Have you ever seen your cat spray urine? YES NO

How often are you finding urine or feces outside the litter box? _____
_____
_____

"CULPRIT": If you have more than one cat, which of your cats is house-soiling? _____
_____
_____
How do you know this cat is the "culprit"? _____
_____

LOCATION: In what room or rooms does your cat house-soil? _____
_____
_____

In what room or rooms (to which your cat has access) does house-soiling NEVER occur?
_____
_____

SUBSTRATE: What is your cat's favorite "surface" for house-soiling (i.e.: carpet, throw rugs, bed, laundry, etc…) _____
_____

TEMPORAL PATTERN: what time of day is your cat most likely to house-soil? _____
_____
_____

LITTER BOX DATA

	LITTER BOX INFORMATION	RESPONSE	
1.	Number of litter boxes in your home:		
2.	How often are your litter boxes scooped? Completely changed?	Scooped:	Changed completely:
3.	What type of litter box(es) do you use? (i.e.: plain, covered, electronic)		
4.	What type of litter do you use? Brand and Type (i.e.: clay, clumping, newspaper)		
5.	Have you tried other litters? If so, which type and brand?		
6.	Do you use a litter box liner?		
7.	Does your cat dig in the litter box BEFORE eliminating?		
8.	Does your cat bury urine and/or feces (at least some of the time) after using the litter box?		

AGGRESSION

Are you having a problem with aggression with your cat? YES NO
If you answered NO, please skip this section and proceed with section marked MEDICAL HISTORY.

TARGET: To whom is the aggression directed? PEOPLE OTHER CAT(S) BOTH

RESPONSE:
Indicate your cat's response to the following situations. Check all that have or have ever applied.

TASK	No response	Hisses	Meows	Snarls	Bites
When approached by person					
When picked up					
When petted/groomed					
When scolded or spanked					
When cat sees other cats in household					
When cat sees other cats outside					
To restrain (i.e. at veterinarians)					
OTHER (describe):					

Has your cat ever been reported to local authorities or public health department for biting? YES NO

Is your pet currently in a 10-day quarantine for biting? YES NO

Any other problems or issues you would like to go over with the Dr.?_____
_____

SYMPTOMS: _____
_____

TECHNIQUES USED BEFORE TO RESOLVE: _____
_____
_____
IT WORKED IT DIDN'T WORK

OTHER:
_____
_____
_____
_____

MEDICAL HISTORY:

Is your pet up-to-date on routine vaccinations, including rabies? YES NO

MEDICATION

NAME OF MEDICATION	DOSE (mg) or Amount	HOW OFTEN?	REASON GIVEN?
1.			
2.			
3.			

OTHER: _____
_____
_____

MEDICAL PROBLEMS:
Please list any medical problems your pet has had recently (within the last year or so)

PROBLEM	**DATES IF KNOWN**	**CHRONIC?**
1.		YES NO
2.		YES NO
3.		YES NO
4.		YES NO

Please add any addition information or comments:

_____
_____
_____
_____
_____
_____
_____
_____

THANK YOU FOR FILLING OUT THIS FORM.