

VCA Mesa Animal Hospital

858 North Country Club Drive, Mesa, AZ 85201

P 480-833-7330 E vcamesa@vca.com vcamesa.com

Canine Behavior Questionnaire

GENERAL INFORMATION

Owner Name: _____

Mailing Address (City/State/ZIP): _____

Email Address (for case consultation only): _____

Preferred Pharmacy (Name/cross streets/phone/fax):

Primary Care Veterinarian (Clinic name/phone): _____

Referred By (Trainer, friend, or other veterinarian than your PCV): _____

PATIENT INFORMATION

Patient's Name: _____ Age: _____

Breed/Color/Sex/Date of Birth (ex: Chihuahua, tan, M, 07/17/2023):

Weight (lbs): _____ Neutered/Spayed, Intact, or Unknown? _____ Age neutered/spayed (yrs): _____

If known, any changes after neuter/spay? _____

Age obtained (yrs): _____ Where was the patient obtained from? _____

If known, behavior of parents or littermates? _____

SECOND PET INFORMATION (for interdog aggression within same household)

Second Pet's Name: _____ Age: _____

What is this second pet's relationship with the patient? ("Aggressor", "Defender", Both, or Unsure)

Breed/Color/Sex/Date of Birth (ex: Chihuahua, tan, M, 07/17/2023):

Weight (lbs): _____ Neutered/Spayed, Intact, or Unknown? _____ Age neutered/spayed (yrs): _____

If known, any changes after neuter/spay? _____

Age obtained (yrs): _____ Where was the pet obtained from? _____

If known, behavior of parents or littermates? _____



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REASON FOR PRESENTATION

Problem	Severe, Moderate or Mild	Length of time problem has existed
1.		
2.		
3.		

If any, has there been a recent change in the frequency of behavior? (describe) _____

Are you or anyone else in the household fearful to live with the patient? (safety concerns, Yes/No) _____

If yes, who? _____

Have you considered euthanasia? (Yes/No) _____ Have you considered rehoming? (Yes/No) _____

What has been done to correct the problems and the outcome? (chronological order)

1) _____

2) _____

3) _____

4) _____

5) _____

Describe the problem behavior, emphasize location of people and other pets if applicable.

Treatment goal(s): _____

FAMILY RELATIONSHIPS

List each family member (humans and pets) living at home with the patient

(Name, Current Age, Sex; if pet, state neutered/spayed/intact/unknown, date obtained, species, and breed)

- _____
- _____
- _____
- _____



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TRAINING

Have you trained yourself or sought formal training services for the patient?

(Yes/No, if no please skip section) _____

Who is/was the trainer(s) and company? (chronological order)

1) _____

2) _____

3) _____

4) _____

5) _____

List if any of the following used: neck collar, electric stimulation collar, head halter, body harness, prong/choke collar, other. _____

List if any of the following used for punishment or training reasons: physical corrections, verbal reprimand, noise corrections, ultrasonic, water sprayer, muzzle grasp, Pinning, time out, booby traps/repellents, other. _____

Would you describe the training as: reward-based, assertive/dominance, assertive/mostly corrections, or other: _____

List what cues or tricks the patient knows (write the % they respond to it):

- _____
- _____
- _____
- _____
- _____

What percentage would you say your dog follow these cues WITHOUT distractions? (0-100%) _____

What percentage would you say your dog follow these cues WITH distractions? (0-100%) _____



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HANDLING / REINFORCER ASSESSMENT

Please select if the patient's reaction to the following is positive or negative:

Activity	Response (Positive/Negative)	If Negative Response (Explain Reaction)
Nail trimming		
Giving pills		
Brushing		
Hugging/kissing		
Rubbing belly		
Patting head		
Grabbing collar		
Lifting		
Rolling over		
Bathing		

If your dog were allowed to have any treat, what would they prefer? List top five:

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____

What other types of rewards does your dog enjoy? (play toys, walks, attention/affection). List top five:

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____



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AGGRESSION SCREENING

Is the aggression directed at one specific person or pet? (Yes/No, state who and if it is people/animals in general) _____

Has the patient ever bitten hard enough to break skin or cause injury? (Yes/No) _____

How old was the patient when initial bite occurred? (yrs) _____

Was there any threatening behavior prior to bite? (eg. growling) _____

Frequency of bites: _____ Total number of bites that broke skin: _____

MEDICAL SCREENING

List any past or present illnesses (name of diagnosis/how long it has been or was present/if perceived as painful)

- _____
- _____
- _____
- _____

List any behavioral medications/supplements used (name/dosage/frequency):

- _____
- _____
- _____
- _____

List any non-behavioral medications/supplements used (name/dosage/frequency):

- _____
- _____
- _____
- _____
- _____

What brand of dog food does your dog eat and how much? _____

Are they intolerant to any food? (if so, then what is it) _____

What is your dog's appetite: voracious, normal, finicky, or decreased? _____



Thank you for filling out this form! Please call **480-833-7330** to set up your initial behavior consultation with Dr. Moffat. We will need a PDF of the referral form and most recent records at time of booking. If you have had a comprehensive blood panel (CBC/CHEM) done in the past, please have it sent. We look forward to hearing from you soon.