

VCA Mesa Animal Hospital

858 North Country Club Drive, Mesa, AZ 85201

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

Feline 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: Tuxedo, black/white, F, 07/17/2023):

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

If known, any changes after neuter/spay? _____

Declawed (Yes/No): _____ If known, any changes after declawing? _____

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

If known, behavior of parents or littermates? _____

REASONS 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? _____

Are you or anyone else in the household fearful to live with the patient? (concerned for their safety).

If yes, who? _____



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

What has been done so far to correct the problems and what was its outcome?

- _____
- _____
- _____
- _____
- _____

Treatment goal(s): _____

FELINE ELIMINATION

Does your cat have an elimination problem? (Yes/No) _____

Does your cat defecate outside litterbox? (Yes/No) _____

Does your cat urinate outside litterbox? (Yes/No) _____

How often does your cat defecate OR urinate outside the litterbox? _____

When is the cat most likely to defecate OR urinate outside the litterbox? _____

Where does the cat defecate OR urinate other than the litter box? (List room(s)/type of surfaces)

Is there any place where your cat WILL NOT soil? _____

Have you observed the cat soil outside the litterbox and what did you do?

Does your cat continue to soil when you are observing? _____

How old was the patient when inappropriate house soiling first happened? (yrs) _____

Any changes in the household when the problem began? _____

What has been tried to correct this problem and what was its outcome?

Tried any other types of litter? Describe the outcome. _____

How often is litterbox changed or cleaned? _____

What type of litterbox do you have (open/enclosed) and location of each box.



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FELINE ELIMINATION CONT'D

Do changes (moving, new furniture, vacations) dramatically affect your cat?

Any straining or pain accompany urination OR defecation? (Yes/No/Both) _____

Any blood in the urine or stools? (If Yes, describe/No/Both) _____

Is stool consistency normal?: (Yes/If No, describe) _____

Increase in volume of urine? (Yes/No) _____

Any increase in drinking? (Yes/No) _____ Any increase in an appetite? (Yes/No) _____

ENVIRONMENT & LIFESTYLE

Brand/type of food: _____

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

List any treats/supplements given (name/dosage/frequency):

- _____
- _____
- _____
- _____

Is the cat ever allowed outdoors? If yes, do cats you DO NOT own visit your property? Patient's reaction if so? (If Yes, describe/No) _____

Is cat ever outdoors unsupervised? If yes, how long? (If Yes, describe/No) _____

GROOMING, SCRATCHING & KNEADING

Does your cat groom itself and if so, does it appear to be (normal, excess, less than expected)?:

When is your cat most likely to groom? _____

Does your cat have a scratching post? (If Yes, describe/No) _____

Does your cat scratch any areas/objects other than the scratching post or play area?

(If Yes, describe/No) _____



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FAMILY RELATIONSHIPS

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

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

- _____
- _____
- _____
- _____

TRAINING

List if any of the following used for punishment or training reasons: physical, noise, ultrasonic, water sprayer, verbal, or other. _____

Have you used a body harness on your cat?: (Yes/No) _____

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)
Restraint on your lap		
Nail trimming		
Giving pills		
Giving liquid medication		
Cleaning/treating ears		
Lifting/carrying		
Patting/stroking		

If your cat were allowed to have any treat, what would they prefer? What types of rewards would entice your cat? (play toys, catnip, attention/affection). List top options:

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



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AGGRESSION SCREENING

If applicable, is the aggression directed at one specific person or pet? _____

If it is people or other animals in general, please state.

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

How old was the patient when initial bite occurred? _____

What are the frequency of bites? _____

Is your cat fearful? (Yes (Mild, moderate, severe)/No) _____

Describe situations where your cat is aggressive:

- _____
- _____
- _____
- _____

MEDICAL SCREENING

List any recent past or present illnesses in chronological order of when diagnosed (name/how long it has been present/if perceived as painful):

- _____
- _____
- _____
- _____

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

- _____
- _____
- _____

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

- _____
- _____
- _____
- _____



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.