**AVIAN HUSBANDRY CLIENT INTAKE FORM**

Species\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age\_\_\_\_\_\_\_\_\_\_\_\_

Sex M F DNA test? Eggs?

Where obtained\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long owned\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Brief reason for today’s visit\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HOUSING**

Describe patient’s primary enclosure\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dimensions \_\_\_\_\_X\_\_\_\_\_X\_\_\_\_\_

What area of the home is the patient kept in?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Substrate\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often is the enclosure cleaned?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Temperature in the room where the patient is kept? Day \_\_\_\_\_\_ᵒF Night \_\_\_\_\_ᵒF

Does patient spend any time out of his/her cage: Y N If yes, is he/she supervised? Y N

How many hours per day?

Any special accommodations (play stand, free standing perches, toys, etc.)?

Light cycle: \_\_\_\_\_\_hrs light \_\_\_\_\_ hrs dark

Is the patient covered at night: Y N

**DIET**

Is fresh water available at all times? Y N

Primary foods offered\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Brand/Where purchased?\_\_\_\_\_\_\_\_\_\_\_\_\_

How often is patient fed? \_\_\_\_\_\_\_\_\_ How much? \_\_\_\_\_\_\_\_\_\_

For birds eating mixed diets, does the patient pick out certain items? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any treats or other food items offered\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supplements Y N If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often are the patient’s dishes washed?\_\_\_\_\_\_\_\_\_\_\_\_ Any detergent used Y N

**MEDICAL HISTORY**

Has the patient ever had any health problems? Y N If yes, please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has the patient ever been seen by another DVM? Y N Clinic or Dr.’s name?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If the patient has been seem by another DVM, may we request records? Y N

**OTHER**

Does anyone in the household use tobacco products? Y N

Is there any use of aerosol sprays, scented candles, incense, etc. in the home? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the patient bathe? Y N If yes, how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any other pets in the home? Y N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_