

DATE: _____



Paw Pups Place Assessment

OWNER

Name: _____ Home phone: _____
 Address: _____ Cell phone: _____
 City: _____ E-mail: _____
 State/Zip: _____ Emergency Contact Info: _____
 Referred by: _____

DOG

Dog's name: _____ Male/Female: _____ Neutered/Spayed: _____
 Breed: _____ Age: _____

PHYSICAL/MEDICAL

Veterinarian name: _____ Phone: _____
 Address: _____ City/State/Zip: _____

Is your dog on any medications?
 Does your dog have medication related side effects?
 Does your dog have any allergies (bee stings, food) / medical issues/etc.? Contagious conditions?
 Does your dog have any physical issues (limping, joint pain, previously torn ACL, etc.)?

BACKGROUND

Where /How did you obtain your dog?
 How long have you owned the dog?
 Have you had a dog before?
 Why are you interested in a leash-free environment for your dog?
 Has your dog previously been in a "leash-free" environment? If so, how long ago, and how did he/she fare?

FEEDING

What do you feed your dog? How often?
 Does your dog receive treats / people food?

HOME LIFE

Any recent changes in your home life? New Home? New family members?

Are there any other pets in the house? What ages?

Are there any other people in the house? Ages?

Is your dog housebroken?

Is your dog crate trained?

Where is your dog when you're not home?

How long is your dog left alone? Have you noticed any separation anxiety?

How do you exercise your dog?

How do you reward your dog?

How do you correct your dog?

Has your dog had any formal training?

Obedience? How Much? How often did they go?

Do they know the 7 Basic commands? Sit, Down, Stay, Come, Heel, Leave It, Off

Do they walk on a leash?

Do they have food or cage aggression?

BEHAVIORAL

Has your dog ever exhibited any of the following behaviors? Give any details:

- | | |
|--|--|
| <input type="checkbox"/> Biting (people, other dogs) | <input type="checkbox"/> Dominance/Mounting |
| <input type="checkbox"/> Open gates/latches | <input type="checkbox"/> Hyperexcitability– how do you calm him/her? |
| <input type="checkbox"/> Barking | <input type="checkbox"/> Jumping / climbing fences |
| <input type="checkbox"/> Fear (noises, people, dogs, etc.) | <input type="checkbox"/> Aggression/raging (handling, people, dogs) |
| <input type="checkbox"/> Digging/scratching | <input type="checkbox"/> Marking |
| <input type="checkbox"/> Resource guarding (food, toys) | <input type="checkbox"/> Other: _____ |