ANIMAL CHIROPRACTIC

OFFICE OF DR. NIKKI L. BECHTOL

OWNER NAME: _____ CONTACT #: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIPCODE: _____

OWNER EMAIL: _____

CIRCLE ONE: CANINE FELINE EQUINE EXOTIC

ANIMAL'S NAME: _____ GENDER: MALE/FEMALE

AGE: _____ BREED: _____ COLOR: _____

WEIGHT: _____ **CIRCLE ONE:** SPAYED/NEUTERED

VETERINARIAN: _____ PHONE #: _____

VETERINARIAN EMAIL (IF AVAILABLE): _____

PLEASE DESCRIBE YOUR CONCERNS REGARDING YOUR ANIMAL:

IT SHOULD BE STRESSED THAT CHIROPRACTIC, IN NO WAY, SHOULD BE THOUGHT OF AS A REPLACEMENT FOR CONVENTIONAL VETERINARY MEDICINE, BUT RATHER AS A VALID, CONCURRENT, COMPLIMENTARY TREATMENT PROCEDURE FOR MANY BACK AND LAMENESS PROBLEMS. IT IS IMPORTANT THAT YOUR VETERINARIAN BE CONTACTED, INITIALLY, SO THAT HE/SHE CAN EXAMINE YOUR ANIMAL FOR UNDERLYING MEDICAL CONDITIONS THAT CAN CAUSE SIMILAR SYMPTOMS.

I GIVE PERMISSION TO DR. NIKKI BECHTOL, DC TO PROVIDE CHIROPRACTIC TREATMENTAND/OR THERAPY ON MY ANIMAL(S).

_____ _____

(OWNER'S NAME) (DATE)