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Canine Behavior Assessment Questionnaire

General Information

Doctor _____

Name _____

Date _____

Address _____

Home # _____ Best time to contact _____

Email Address _____

Pet Information

Pet Name _____ Breed _____

Weight _____ Age _____ Sex M F Neutered/Spayed Y N Age _____

Any changes after neutering? _____

Where did you obtain this pet? _____

Breeder (if applicable) _____

Behavior of parents or litter mates _____

Currently on any medication? _____

Environment / Lifestyle

For what purpose did you get your pet? Companion Show Breeding Working

Age Obtained _____ Amount Fed _____

Type of food _____ Frequency of feeding _____

When fed _____ Where fed _____

Who feeds (describe eating) _____

Favorite treat _____ Supplements given _____

Favorite game _____ Type of exercise _____

Amount/ Frequency of exercise _____

Amount/Frequency of play _____

Favorite toy(s) _____

Describe where your dog stays at each of the following times:

Daytime (owner away) _____

Daytime (owner home) _____

Night time _____

When guests visit _____

How long is the dog alone each day? _____

Dogs reaction when left alone _____

Reaction prior to departure _____

Reaction to homecoming _____

Ever alone outdoors? Y N How often? _____

How long (average) each day? _____

Where is the dog when outside? _____ Fenced in back yard Y N

Type of dwelling Farm Apt House Other

How does your dog react to car rides? _____

Is your dog ever alone in a car? Y N How long? _____

Family Relationships

List each family member include sex and age: _____

Which family members have the best control? _____

Which family members have the least control? _____

List all other pets, including breed, age, and sex: _____

Describe how your pets get along with each other: _____

Training

Has your dog had obedience training? Y N Was it successful? Y N

Where? _____

What can your dog do on command? _____

Have you ever used a Gentle Leader? Y N

Briefly describe your dogs personality: _____

Handling

How does your dog react to the following?

Nail trimming _____ Cleaning Ears _____

Giving Medication _____ Grooming/Bathing _____

Patting Head _____ Rubbing Belly _____

Being Lifted _____ Rolling Over _____

Grasping Collar _____

Familiar dogs on property _____

Familiar dogs off property _____

New dogs on property _____

New dogs off property _____

Strangers on property _____

Strangers off property _____

Strangers arriving indoors _____

Other animals _____

Crate Training

Has your dog been crate trained? Y N Do you still use the crate? Y N

Crate Type: _____ Location: _____

Punishment

Physical _____ Noise _____

Water Sprayer _____ Verbal _____

Has any punishment made the problem worse? Y N If yes, describe: _____

Aggression

Is your dog aggressive to family members? Y N If yes, who? _____

List any other people your dog is aggressive toward _____

Has your dog ever bitten hard enough to break the skin or cause injury? _____

Does your dog ever bark threateningly? Y N

Describe any other situations where your dog growls or acts aggressive: _____

Does your pet ever threaten or act aggressive in any of the following situations?

Petting Y N While Eating Y N

Chewing Objects Y N When sleeping Y N

Punishment / Discipline Y N People entering home Y N

People entering yard Y N People off property Y N

Other dogs off property Y N Other dogs on property Y N

If yes to any of the above, indicate and describe: _____

Was there an illness or health problem when the aggression started? _____

When your dog is aggressive, what is your response? _____

Fear Aggression

Does your pet act fearful at the time of aggression? Y N

What is the primary problem (aggressive, house soiled, destructive, barking, etc.)? _____

How would you describe the severity of this problem? Mild Moderate Severe

Have you considered euthanasia? Y N

Describe the problem beginning with the most recent incident: _____

What age was your pet when this began? _____

Describe the first incident: _____

How often does this problem occur? _____

Has there been a recent change in frequency or severity? Y N If yes, describe _____

Were there any changes in the home when the problem first appeared? _____

Have you actually seen the problem? Y N If yes, what did you do? _____

What has been done so far, to try and correct the problem? _____

What was the dog's response? _____

List any techniques that have had any success: _____

List any techniques that have made the problem worse: _____

Have any drugs been used so far, and the dog's response to the medication? _____

What do you think is the reason for your dog's problem? _____

Additional Comments: _____

Additional problems:

Destructive digging	<input type="checkbox"/> Y <input type="checkbox"/> N	Destructive chewing	<input type="checkbox"/> Y <input type="checkbox"/> N
Barking	<input type="checkbox"/> Y <input type="checkbox"/> N	Howling	<input type="checkbox"/> Y <input type="checkbox"/> N
Whining	<input type="checkbox"/> Y <input type="checkbox"/> N	House soiling - Urine	<input type="checkbox"/> Y <input type="checkbox"/> N
House soiling - Stool	<input type="checkbox"/> Y <input type="checkbox"/> N	Stool eating	<input type="checkbox"/> Y <input type="checkbox"/> N
Chasing	<input type="checkbox"/> Y <input type="checkbox"/> N	Jumps up (owners)	<input type="checkbox"/> Y <input type="checkbox"/> N
Jumps up (guests)	<input type="checkbox"/> Y <input type="checkbox"/> N	On furniture where not permitted	<input type="checkbox"/> Y <input type="checkbox"/> N
In rooms where not permitted	<input type="checkbox"/> Y <input type="checkbox"/> N	Garbage raiding	<input type="checkbox"/> Y <input type="checkbox"/> N
Food stealing	<input type="checkbox"/> Y <input type="checkbox"/> N	Pushy (wants own way)	<input type="checkbox"/> Y <input type="checkbox"/> N
Won't come when called	<input type="checkbox"/> Y <input type="checkbox"/> N	Mounting	<input type="checkbox"/> Y <input type="checkbox"/> N
Urine marking	<input type="checkbox"/> Y <input type="checkbox"/> N	Chews / Licks self	<input type="checkbox"/> Y <input type="checkbox"/> N
Tail biting	<input type="checkbox"/> Y <input type="checkbox"/> N	Fly chasing	<input type="checkbox"/> Y <input type="checkbox"/> N
Uncontrollable urination (excited)	<input type="checkbox"/> Y <input type="checkbox"/> N	Uncontrollable urination (frightened)	<input type="checkbox"/> Y <input type="checkbox"/> N