



Petsittingbycindy.business.blog

208-315-5558

Pet Sitting by Cindy



Pet Care Information

Owner Name: _____

Address: _____

E-Mail: _____ Phone: _____

Visit Dates and Times:

From _____ To _____

Number of Visit per day: Morning _____ Afternoon _____ Evening _____

Pet Information

Number of Pets: Dogs _____ Cats _____ Other _____

Pet Name: _____ Breed: _____ Age: _____

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Pet Name: _____ Breed: _____ Age: _____

Is your pet spayed/neutered? Yes No

Does your pet have any health issues? Yes No

If so, please explain _____

Dogs:

Location of bowls/food/treats _____

Brand of food _____

Feeding amount _____ Times per day _____

Location of leashes _____ Poop bags _____ Toys _____

Allergies: _____

Medication Type and Dosage: _____

Cleanup supplies for accidents _____

Where to leave dog after visit: Kennel In a specific room Free to roam entire house

Other _____

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Behavioral Problems:

Aggression toward dogs or people? Yes No

If so which: Dogs People

Separation anxiety: Yes No

If so, please explain:

House training: Yes No

Leash reactivity: Yes No

Favorite hiding spots: _____

Cats:

Location of bowls/food/treats _____

Brand of food _____

Feeding amount _____ Times per day _____

Litter box supplies _____ Toys _____

Allergies: _____

Medication Type and Dosage: _____

Cleanup supplies for accidents _____

Where to leave pet after visit: Kennel In a specific room

Free to roam entire house

Other _____

Behavioral problems: Biting Scratching Separation anxiety

Other _____

OTHER PETS :

Type: Rodents _____ Reptiles _____ Birds _____ Rabbits _____

Other _____

Type of food _____ Feeding amount _____ Times per day _____

Location of cage _____ Cleaning supplies _____

How often to clean cage _____ Where to dispose of waste _____

Type of enrichment/play activities if any _____

Does your pet bite? Yes No If yes please explain: _____

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IMPORTANT PHONE NUMBERS:

Main contact number(s) _____

Neighbor, friend or family number _____

Will pet care duties be shared with anyone not affiliated with Pet Sitting by Cindy? YES NO

Details of job sharing arrangements _____

Name and Phone number of person sharing Responsibilities _____

HOME CARE: Lights rotated? Draperies/blinds Water house plants

TV/Stereo Bring in newspaper Mail Mail box # _____

Location of trash can _____

Trash pickup date and time _____

YARD CARE: Pooper scooper location _____

Where to dispose of waste? _____

Location of sprinklers _____ Frequency/duration _____

Hand Watering of outdoor plants Frequency _____

KEYS House key tested Gate key tested Mail box key tested

Does anyone else have a key to your house? Yes No

If YES, who: _____

OTHER INSTRUCTIONS: _____

PAYMENT OPTIONS: Cash Check Credit Card