FELINE ELIMINATION BEHAVIOR QUESTIONNAIRE

Four Paws Animal Hospital & Wellness Center
Phone: 540-898-5388
Fax: 540-898-4200

Please fill out this form carefully and completely. The information you provide will be important for diagnosing and treating your pet's behavior problems. The more complete and accurate the information, the more help we will be able to provide.
This form must be returned to the hospital and all consultation fees paid at least 48 hours prior to your appointment or phone consultation in order to give the Doctor time to review the information.
After your behavior consultation with the Doctor, you will be provided with written recommendations and a follow-up phone consultation will be conducted to check on your pet's progress made and to see if you have any additional questions.

Owner: _____ Pet's name: _____ Date: _____

❑ Check this box if you do not know which pet in the house is the source of the inappropriate elimination. Answer the remaining questions with the understanding that the above named cat is only suspected to be the source.

GENERAL INFORMATION

At what age did you obtain the pet: _____

Have you had cats before? ( ) Yes ( ) No

Where did you obtain this pet?
❑ Friend
❑ Breeder
❑ Shelter
❑ Pet store
❑ Rescue group
❑ Family member
❑ Other _____

Why did you choose this specific animal? _____

For what purpose was this pet obtained?
❑ Companionship for me/family member
❑ Companionship for another pet
❑ Breeding
❑ Showing
❑ Was a gift from someone else
❑ Other _____

Has this pet had other owners? ( ) Yes ( ) No If yes, how many? _____ ( ) Unknown

PET'S ENVIRONMENT

What percentage of the day does you pet spend indoors? _____ % Outdoors _____ %

Is this pet left alone during the day? Yes ( ) No ( ) If so, how long?_____

What kind of living situation do you have? ( ) Apartment ( ) Townhouse/Condominium
( ) House with small yard ( ) House with large yard ( ) Farm

What toys/types of play does the pet enjoy?

How many times per day do you play with the pet (on average)? _____

About how long does each play session last? _____

List the number of other pets in the home. Please label which pet was obtained first, second, etc:

Name	Species & Breed	Sex	Spayed or neutered?	Age obtained	Age now	Order obtained

What is your pet's relationship to the other animals (*e.g.* friendly, hostile, fearful)? Please describe.

How does this pet react to unfamiliar people (hides, wants to sit in their lap, ignores, etc)?

Please list the people, including yourself, currently living in the household.

Name	Sex	Age	Relationship (self, husband, etc)	Interacts with cat on regular basis?	Does cat seem afraid of this person?

MEDICAL HISTORY

List all major surgical or medical problems (bladder stones, arthritis) and approximate dates:

List all medications (including dosage and schedule) currently being taken by this pet. Please include heartworm/flea/tick preventatives and any supplements or vitamins:

About how many times a day does your cat urinate? _____ Defecate_____ ?

Is your cat declawed? ( ) Yes ( ) No

Is your cat neutered or spayed? Yes [ ] No [ ] If so, at what age? _____

If your cat is not neutered, do you plan on breeding them? ( ) Yes ( ) No

Has this cat ever been bred? ( ) Yes ( ) No ( ) Unknown

If female, did she experience heat cycles before spaying? ( ) Yes ( ) No ( ) Unknown

LITTER BOXES

How many litter boxes do you have? _____ How often are they scooped? _____

How often are they dumped and completely cleaned _____? With what product(s)_____ ?

In multi-cat households do the cats: □ always use a particular box, or □ does it seem random?

Describe the litter boxes (check all that apply and put in parentheses the number of boxes for which the description is true).

❑ Covered	( )	❑ Small (about length of cat)	( )	❑ Liner	( )
❑ Open	( )	❑ Shallow	( )	❑ No liner	( )
❑ Large (at least 1 ½ times the length of the cat)	( )	❑ Deep/tall sides	( )	❑ Lit at night	( )

What kind of litter material do you put in the box(es)? Check all that apply.

❑ Plain, non-clumping clay	❑ Varies	❑ Wheat husks
❑ Clumpable	❑ Dirt or soil	❑ Recycled, pelleted newspaper
❑ Deoderized or scented	❑ Crystals	❑ Shredded paper
❑ Sand	❑ Sawdust / wood chips	❑ Other _____

Where are the litterboxes located (check all that apply)?

❑ Closet	❑ Bedroom	❑ Pantry
❑ Laundry room	❑ Attic	❑ Stairwell
❑ Kitchen	❑ Basement	❑ Other _____
❑ Bathroom	❑ Entryway	

It is very helpful if you are able to provide a simple sketch / floor plan of your home on a separate sheet(s) of paper that indicates where the litter boxes are. Important information to indicate on the sketch includes:

- Location of boxes
- Major furniture items (couches, beds, etc)
- External windows and doors
- Hallways and interior doorways
- Stairs
- Major appliances (washer, dryer)
- Any areas where your cat has eliminated outside the box (can indicate by writing “urine” or “feces” over those areas).
- Locations of food and water
- Any favorite resting areas and for which cat (can indicate with pet’s name followed by an R inside a circle)
- Location of scratching posts (can indicate with “SP” inside a circle)
- Rooms labeled (bedroom, bathroom, etc)

□ Please check here if floor plans were submitted with this questionnaire.

Indicate if your cat does the following when using the litter box (check all that apply):

❑ Scratch/dig in the litter before eliminating	❑ Calmly and slowly exits the box
❑ Sniff around the litter before eliminating	❑ Leaps / runs out of the box as soon as they are done eliminating
❑ Covers up elimination before leaving the box	❑ Vocalizing
❑ Scratches outside the box either before or after eliminating	❑ Straining
❑ Misses the box and ends up eliminating outside the box	❑ Multiple trips in and out of the box

BEHAVIOR PROBLEM INFORMATION

What kind of elimination is occurring outside the box: ___urine ____ stool ____ both

Please indicate the approximate percent of time the cat:
_____% eliminates inside the box _____% eliminates outside the box _____% eliminates outside

How long has the inappropriate elimination been going on? _____

About how many times per week does you pet eliminate outside the box? _____

Do you feel like it has gotten better or worse over time? _____

FOR URINATION ONLY:
Soiled areas are usually found on (please check all that apply):

- ❑ Horizontal surfaces (floor, middle of bed)
- ❑ Vertical surfaces (walls, side of couch)
- ❑ Both vertical and horizontal surfaces
- ❑ Clothing (Ex: on floor or in hamper)
- ❑ Furniture
- ❑ Walls
- ❑ Around doorways
- ❑ Windows
- ❑ Carpet
- ❑ Throw rugs
- ❑ Other personal items (backpacks, etc) _____
- ❑ Other _____

Have you witnessed it occur? _____ yes ____ no
If yes: Does your cat wiggle their tail or tread their rear feet while urinating? ___ yes ___ no ____ sometimes
Does the urine come out in spurts? ____ yes ____ no _____ can't tell
Would you describe is as ____ large volume ____ small volume ____ varies

FOR DEFECATION ONLY:
Stools look (check all that apply):

- ❑ Hard / dry
- ❑ Diarrhea
- ❑ Have blood in it
- ❑ Have mucous in it
- ❑ Normal
- ❑ Unusually small volume
- ❑ Unusually large volume
- ❑ Other _____

How have you cleaned the soiled areas (please include product names if possible)?

Do you feel like you have been successful in removing all smells from past accidents? _____

What has been done so far to correct the problem? (changing litter, adding boxes, punishment, medications, etc.)

What was the pet's response?

Were there any significant changes in this pet's environment prior to the appearance of this problem? (Please check all that apply)

- ❑ Moved or redecorated
- ❑ Pet was boarded
- ❑ Visitors (human or pet)
- ❑ Type of litter changed
- ❑ Stray animals appeared outside
- ❑ Change in family schedule
- ❑ New family member/roommate
- ❑ Diet change
- ❑ Death of human in family
- ❑ Death of pet in family
- ❑ Family member moved out
- ❑ Baby born
- ❑ Pet added
- ❑ No changes noted

Are there any other changes that have accompanied your cat's inappropriate elimination? (Check all that apply):

❑ Change in appetite
❑ Frequency of drinking
❑ Frequency of urination
❑ Blood in urine
❑ Blood in stools
❑ Change in activity
❑ Change in weight
❑ Other _____

Please indicate any other behavior or training problems that your cat has (check all that apply):

❑ Destructive chewing
❑ Grooming abnormalities
❑ Climbing
❑ Swallows non-food items
❑ Abnormal sleeping patterns
❑ Shy / Fearful
❑ Scratching people
❑ Aggressive
❑ Excessive vocalizing
❑ Bites
❑ Fights
❑ Runs away
❑ Destructive scratching
❑ Other _____

Why have you kept the pet despite its behavior problems?

Have you considered finding another home for this pet? ( ) Yes ( ) No

Have you considered euthanasia (putting your pet to sleep)? ( ) Yes ( ) No

Please discuss in detail any other information that you feel is relevant to your pet's problem:

Staff Use Only:

Account # _____	☐ Paid on _____	☐ Appt with Dr. _____ on _____	
☐ Phone consultation with Dr. _____ on _____	1 / 2 / 3 8am – 12pm Call 1st _____ Call 2nd _____	1 / 2 / 3 12pm – 4pm Call 1st _____ Call 2nd _____	1 / 2 / 3 4pm – 7pm Call 1st _____ Call 2nd _____