Training Evaluation Questionnaire

Owner's Name	Dog's Name
St. Address	Breed
City Zip Code	Sex Date of Birth
Telephone (work/cell)	Date Dog Acquired
Telephone (home)	Today's Date
Veterinary Clinic	Vet's Telephone
Email Contact	How were you referred?

CHECK THE FOLLOWING PROBLEMS YOU WOULD LIKE CORRECTED

- ☐ Aggression towards people
- ☐ Aggression toward dogs
- ☐ Jumping on people
- ☐ Pulling on leash
- ☐ Digging
- ☐ Excessive barking
- ☐ Housebreaking
- ☐ Destructive chewing
- ☐ Getting on furniture
- ☐ Getting into garbage
- ☐ Mouthing/Biting
- ☐ Showing fear
- ☐ Separation Anxiety
- ☐ Resource Guarding

CHECK THE LEVEL OF TRAINING YOU ARE CONSIDERING

- ☐ Basic Obedience – Complete on-leash control
- ☐ Advanced Obedience – Complete off-leash control
- ☐ Other

DESCRIBE THE GENERAL BEHAVIOR OF YOUR DOG

In Your House ______________________________

Reaction to Strangers at the Door ______________________________

In Your Yard ______________________________

On the Street ______________________________

At the Park ______________________________

In Your Car/Truck ______________________________

Attitude Towards Children ______________________________

Has your dog ever bitten? __ *YES* ___ *NO* *If yes, describe the circumstances:*

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