



**Canine  
Companion  
Consulting**

**GROUP TRAINING ENROLLMENT FORM**

**CLIENT INFORMATION:**

Pet Parents Name (s): \_\_\_\_\_

Address: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you hear about us: \_\_\_\_\_

Veterinarian's Name/Phone: \_\_\_\_\_

Current Medical problems: yes / no Last Vet visit: \_\_\_\_\_

Please check all the behaviors that you would like assistance with:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Agility        | <input type="checkbox"/> Biting             | <input type="checkbox"/> Door Manners               |
| <input type="checkbox"/> Jumping        | <input type="checkbox"/> Kennel training    | <input type="checkbox"/> Stealing objects           |
| <input type="checkbox"/> Down           | <input type="checkbox"/> Leash walking      | <input type="checkbox"/> Leave it                   |
| <input type="checkbox"/> Stay           | <input type="checkbox"/> Recall             | <input type="checkbox"/> Training with distractions |
| <input type="checkbox"/> Sit            | <input type="checkbox"/> Aggression         | <input type="checkbox"/> Barking                    |
| <input type="checkbox"/> Chewing        | <input type="checkbox"/> Separation Anxiety | <input type="checkbox"/> Other: _____               |
| <input type="checkbox"/> Potty training |   |   |

Dog's Name: \_\_\_\_\_ Dog Breed: \_\_\_\_\_ Date Adopted: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: M / F

Has your dog ever bitten a human? Yes / No

Has your dog ever bitten another dog? Yes / No

Is your dog reactive on leash to dogs or humans? Yes / No

Is there anything else we should know about your dog?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PAYMENT INFORMATION:**

\_\_\_\_ Check payable to 'Canine Companion Consulting' or 'CCC'

\_\_\_\_ Credit card: <https://squareup.com/store/canine-companion-consulting>