



CLIENT INFORMATION

Full Name: _____ Spouse/Partners Name: _____

Home Address: _____

Telephone Numbers (checkmark your primary contact number):

Home: Cell: Work:

Email Address: _____

- *Please note that we send monthly e-newsletters containing articles and promotions from our doctors.*

Date of Birth (required if controlled substances are prescribed): _____

How did you hear about Alternatives for Animals?

Newspaper: Website: Friend referral:

Professional referral: Other:

Alternatives for Animals is a holistic veterinary wellness center focusing primarily on Traditional Chinese Medicine, Bioresonance therapy, K-Laser therapy, chiropractic, massage, homeopathy, Bach Flower remedies, and pulse signal therapy. Certain pharmaceuticals are prescribed when necessary. Should patients require anesthesia, radiographs, surgery or other in-hospital procedures, you will be referred to your conventional veterinarian, or to a full-service veterinary hospital in the city of your preference.

Signature _____ Date _____



HOLISTIC INTAKE QUESTIONNAIRE

Client Name: _____ Date: _____

Patient Name: _____ Date of Birth: _____

Breed: _____ Color/Markings: _____

Male

Female

Neutered

Spayed

Chief complaint:

Previous medical history:

Current medications and supplements, including the dosage:

Any history of food or drug sensitivity? YES NO

If so, how?

Current diet:

Does weather, season or time of day affect the symptoms of the main complaint? YES NO

If so, please describe:

Describe your pet's personality and how they interact with other animals or people:

Does your pet have any fears or phobias? YES NO

If so, please describe:

Has your pet had any litters? If so, how many? _____

Date of spay or neuter surgery: _____

History of any other surgeries or trauma? _____

Vaccine history:

Canine

DA2PP #1 _____ DA2PP #2 _____ DA2PP #3 _____ Last booster _____

Lepto _____ Rabies 1 year _____ Rabies 3 year _____

Any vaccine reactions? _____

Feline

FVRCP #1 _____ FVRCP #2 _____ FVRCP #3 _____ Last booster _____

FeLV/FIV _____ Rabies 1 year _____ Rabies 3 year _____

Any vaccine reactions? _____

Review of Symptoms:

1.) Gastrointestinal tract:

Flatus	YES	NO
Constipation	YES	NO
Vomiting	YES	NO
Diarrhea	YES	NO
Mucus on stool	YES	NO
Burping	YES	NO
Borborygmi (noisy intestines)	YES	NO
Incomplete bowel movements	YES	NO
Straining to defecate	YES	NO
Fecal Incontinence	YES	NO

2.) Respiratory:

Coughing	YES	NO
Sneezing	YES	NO
Reverse sneezing	YES	NO
Wheezing	YES	NO
Abnormal breathing	YES	NO
Panting excessively	YES	NO
Snoring	YES	NO

3.) Cardiovascular:

Poor stamina	YES	NO
Heart murmur	YES	NO
Other known heart condition	YES	NO

If yes, please describe: _____

4.) Musculoskeletal:

Stiffness	YES	NO
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If so, where? _____

Soreness	YES	NO
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If so, where? _____

Difficulty getting up or jumping	YES	NO
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Muscle wasting	YES	NO
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Abnormal gait	YES	NO
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5.) Integument/Skin:

Dandruff	YES	NO
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Rash	YES	NO
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Pruritis (itching)	YES	NO
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Oiliness	YES	NO
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Hair loss	YES	NO
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Wounds with discharge	YES	NO
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Hot spots	YES	NO
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Frequent anal gland issues	YES	NO
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Location of any lesions:

6.) Urologic:

Urinary incontinence	YES	NO
Straining to urinate	YES	NO
Cystitis (infection)	YES	NO
Increased urination	YES	NO
Malodorous urine	YES	NO
Color of urine	Dark	Light
Discharge from prepuce or vagina	YES	NO

7.) Head, ears, eyes, nose, throat:

Loss of vision	YES	NO	
Cloudiness of lens	YES	NO	
Loss of hearing	YES	NO	
Discharge from eyes	YES	NO	
If so, which eye?	Left	Right	Both
Ear infection	YES	NO	
If so, which ear	Left	Right	Both
Halitosis	YES	NO	
Eye lesions	YES	NO	
Oral lesions	YES	NO	
Gingivitis	YES	NO	
Bad dental disease	YES	NO	
Date of last dental:	_____		

8.) Neurological:

Seizures	YES	NO
Head tilt	YES	NO
Incoordination	YES	NO
Dragging limb(s)	YES	NO

9.) General physical signs:

Please describe your pet's characteristics with the following:

- Appetite

- Thirst

- Temperature preference (i.e. seeks cool or warm areas)

- Temperature at various places of the body

- Sleep signs (i.e. restlessness, dream filled, deep, falls asleep easily)

- Energy level in morning vs. afternoon vs. evening

If there is any other pertinent information, please list here:

End of questionnaire - Thank you!