(512) 282-0221

8106 Brodie Lane, Suite 102
Austin, TX 78745

Date: _____

Acupuncture and Herb Consult

Please list previous medical history *(severe illness and trauma)*. Please include dates:

What is the current health or behavior problem?

Is there any pain in the body? If so can you list where?

Does your pet prefer heat (*lays in the sun, or on a bed*), or do they prefer cold?

Appetite: (*circle one*)	Poor	Fair	Good	
Thirst: (*circle one*)	Little	Normal	Excessive	
Sleep: (*circle one*)	Good	Disturbed or Anxious at night		
Urination: (*circle one*)	Frequent & a lot	Freq but a little	Normal	Strong odor / Normal odor
Stools: (*circle one*)	Formed	Loose	Alternates	Hard and sometimes constipated / Strong odor / Normal or no odor
Vomits: (*circle one*)	Never or Rarely	Daily	Weekly	Food
	Bile(*yellow*)	White foam	Strong odor	Normal or no odor
Predominate Emotions: (*circle one*)	Fearful	Worried	Depressed	Happy and tail wagging a lot / Sad / Dominant and sometimes aggressive
Any emotional upset in the family recently: (*circle one*)			Yes	No
Hearing: (*circle one*)	Normal	Reduced	Deaf	**If yes, how long?**
Vision: (*circle one*)	Normal	Reduced	Blind	**If yes, how long?**
List all current medications and dosages:				
List all nutritional supplements or herbs currently given, and dosages:				
What diet does your pet eat?				
How much?			**How often?**	
Does your pet have any current blood profiles or x-rays? (*circle one*)			Yes	No
Are you interested in these diagnostic tools if the Doctor feels they are necessary? (*circle one*)			Yes	No
Any additional information that you feel is important?				