

Patient Name: _____ Species: _____ Age: _____

Alternative Medicine Consultation

Please list previous medical history (Severe illness & 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 sun/on bed) _____ Cold? _____

Appetite: Poor _____ Fair _____ Good _____

Thirst: Little _____ Normal _____ Excessive _____

Sleep: Good _____ Disturbed or Anxious at night _____

Urination: Freq. & alot _____ Freq. & a little _____ Normal _____

Urine Odor: Strong _____ Normal _____

Stools: Formed _____ Loose _____ Alternates: _____

Hard, sometimes constipated: _____

Stool Odor: Strong _____ Normal/Not much smell _____

Vomit: Never or Rarely _____ Daily _____ Weekly _____

Food _____ Bile (Yellow) _____ White foam _____

Vomit Odor: Strong _____ Normal/No odor _____

Predominate Emotions: Fearful _____ Worried _____ Depressed _____

Happy & Tail wagging _____

Dominant & sometimes aggressive _____

Any emotional upset in the family recently: Yes _____ No _____

Hearing: Normal _____ Reduced _____ Deaf _____, yes how long? ____
Vision: Normal _____ Reduced _____ Blind _____, yes how long? ____

List all current medications and dosages:

List all nutritional supplements or herbs currently giving and dosages:

What does your pet eat: _____

How much: _____ How Often: _____

Does your pet have any current blood profiles or X-rays: Yes _____ No _____

Are you interested in these diagnostic tools, if the Doctor feels they are necessary?

Yes _____ No _____

Any suspect allergies:

Food: _____

Seasonal: _____

Medication: _____

Does anyone in the household smoke: Yes _____ No _____

Most important health concerns:

1. _____
2. _____
3. _____

Any additional information you feel is important:
