Acupuncture Intake History

Please answer the following questions, if known.

Your name: __________________________________________________________

Your pet’s name: ______________________________________________________
Species: ________________________ Breed: ________________________________
Age: ___________  Sex: ___________ Color/Markings: _______________________

Who is your pet’s regular veterinarian? ____________________________________
_______________________________________________________________________
_______________________________________________________________________

Vaccine history: (please include dates)

**Cats:** Rabies __________ FVRCP __________ FELV __________
FIV/FELV test date and result: ____________________________________________
Indoor/Outdoor? _______________________________________________________
Deworming history: (please include dates) _________________________________

**Dogs:** Rabies __________ DHPP __________ Lyme __________
Leptospirosis ___________ Kennel Cough ___________
Canine Influenza _______________________________________________________
Heartworm test date and result: _________________________________________
Deworming history (please include dates) _________________________________

Has your pet had any recent labwork? If so, can you please provide a copy of the results? ________________________________

Has your pet had any recent x-rays? If so, can you please provide a copy of the results? ________________________________

Current diet and portions (include treats as well): _____________________________
_______________________________________________________________________
_______________________________________________________________________

What medications does your pet currently take? (Please include prescription or over-the-counter medications and supplements, the dose, and frequency of administration): ________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
General History:

1. What is the chief complaint? ______________________________________
_________________________________________________________________
_________________________________________________________________

2. When did it start? (i.e. Time of day? Seasonal? After rest? After eating?)
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

3. What treatments have been tried? Did they work?______________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

4. Has your pet had any adverse reactions to medications? ________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

5. Does your pet have any other health problems, unrelated to your chief
complaint? _________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

6. Has your pet had acupuncture for this problem in the past? ______________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

7. Has your pet been treated with Chinese herbs for this problem in the past?
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

8. If you could give your pet a job, what would it be? (i.e. a teacher, a public
speaker, a scientist, etc?)____________________________________________
_________________________________________________________________
TCVM History:

1. Does your pet exhibit any coughing or sneezing? Yes ______ No _______
   If your pet is coughing, is it: Loud ______ Soft ______
   ------------------------

2. How is your pet’s appetite?
   Normal ______ Voracious ______ Reluctant ______
   If your pet’s appetite is voracious, is he or she full after only a couple of
   bites of food? Yes ______ No _______
   ------------------------

3. Does your pet experience vomiting? Yes ______ No _______
   If you answered Yes, does your pet:
   Vomit immediately after eating? Yes ______ No _______
   Belch often or have increased stomach noise? Yes ______ No _______
   Lick surfaces or his or her paws often? Yes ______ No _______
   Vomit mostly over night/early in the morning? Yes ______ No _______
   Vomit several hours after eating? Yes ______ No _______
   Vomit food? Yes ______ No _______
   Vomit bile? Yes ______ No _______
   ------------------------

4. How are your pet’s stools? Normal ______ Abnormal ______
   If abnormal, are your pet’s stools:
   Loose? ____ Dry? ______
   Any mucus? ______ Any blood? ______
   ------------------------
   If you’ve noted blood in the stools, is it:
   Bright red blood? ______ Black, tarry blood? ______
   Does your pet strain to have a bowel movement?
   Yes ______ No _______
   If your pet is straining, is it due to dryness or weakness? ______
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   Does your pet strain to have a bowel movement and then feel
   better? __________________________
   ------------------------
   Does your pet strain to have a bowel movement and then feel
   worse (i.e. worn out afterwards)? __________________________
   ------------------------

What is the shape of your pet’s stools?
   Thin, ribbon-like? __________________________
   Dry? __________________________
   Pellets? __________________________
5. How is your pet’s thirst?  Normal ___________  Abnormal __________
   If you answered abnormal, is the thirst:
   Increased? ___________  Decreased? __________
   If you answered increased, does your pet:
   Drink a lot all the time? __________________________________
   Drink only small amounts after repetitive visits to the water bowl?

6. How is your pet’s urine?  Normal ___________  Abnormal __________
   If you answered abnormal, is your pet’s urine:
   Increased in frequency? Yes ___________  No _________
   Copious amounts and odorless? Yes ___________  No _________
   Dark, frequent urinations with strong odor? Yes _____ No ___

7. Does your pet seek:  Cool surfaces ___________ Warm surfaces ___________
   Firm surfaces ___________ Soft surfaces ___________

8. Does your pet seem restless or fidgety?  Yes _________  No _________
   If you answered yes, is it:
   All the time? __________________________________
   Worse in the evening/night time? _______________________

9. Does your pet rub his or her face?   Yes _________  No _________
   If you answered yes, does he or she rub:
   All of the face? ____________________________________
   Mostly the corners of the mouth and lips? __________________

10. How is your pet’s energy? Normal _________  Decreased _________
    If you answered decreased, does your pet’s energy level:
    Get better as the day moves on?  Yes ______  No _________
    Get worse as the day moves on?  Yes ______  No _________