Holistic Intake Form

Date: ____________________

Owner Information

Client Name: ____________________

Phone Number: ____________________

Email: ____________________

Regular Veterinarian or Veterinary Hospital: ____________________

Animal Information

Dog __________ Cat __________ Other: __________

Name: ____________________ Breed: ____________________

Age: ____________________ Gender / Neutered or Intact ____________

Chief Complaint

When did this first begin? ____________________

Is the condition changing over time? ____________________

Other problems? ____________________

Current supplements: ____________________

Current medications: ____________________

Which Supplements or medications seem to be making the most difference in the condition?

____

Personal / Family History

Are there other pets in the house? ____________________

Where does he/she rank among other household members (human and animal)?

____

What is his/her personality like (dominant, submissive, passive, aggressive, etc)?

____

Has he/she ever expressed any unusual aggression? (Explain)

____

Is he/she possessive? (toys, people, food, etc) ____________________

What mental or emotional observations would you make about him/her? (likes to be fussed over, is clingy, etc.)

____

Does he/she have any irrational fears? (thunder, fireworks, etc)? ______________________

How does he/she react to new or unusual situations or people?

____

How does he/she behave when people come to the house?

____

Does he/she exhibit particular symptoms when stressed out?

____

How does he/she react to being reprimanded?

____

Have there ever been personality changes? ________ When? ________________________

Does he/she like to lie in the sun or shade? On hard or soft surfaces?

____

Does he/she prefer physical activity or a more sedentary life?

____

Has he/she ever displayed any obsessive compulsive behaviors?

____

Have you ever used alternative modalities before? ______________________________

Has he/she ever had any allergic responses to anything?

____

Is he/she affected by weather? ____________________ Season? __________________

Where does he/she usually sleep? ____

In what position does he/she lie? ____

How does he/she tell you he/she is ill? _____________________________________

Describe him/her in (3) three words: _______________________________________

Physical History

Eye Issues: Discharges (color, texture, amount) ______________________
Vision changes: ______________________
Lens health/cataracts: ______________________

Ear Issues: Discharges: ______________________
Color/texture/odor: ______________________
Hearing changes: ______________________

Nose: Discharges/color/frequency/seasonalities?: ______________________
____

Respiratory Issues:
Breathing (rough, moist, wheezing, snoring): ______________________
Coughing (dry, moist, forceful, weak, hacking, seasonal, weather related):
____

GastroIntestinal:

Mouth: teeth, gums, salivation: ______________________
Appetite: amount, time, rate of eating: ______________________
Thirst: high/low/normal, small sips/tank up: ______________________
Vomiting: color, consistency, mucous, timing (immediately after eating?), frequency, violence:
____

Stomach sounds: gurgling, gas: ______________________
Feces: Normal, loose, diarrhea, constipation: ______________________
Mucous or blood in stools? ______________________
Straining? ______________________
Odor: strong? ______________________
Color: ______________________

Immunological History

What vaccines have been given in the last year? ______________________
Has he/she ever had an adverse reaction to a vaccine? ______________________
Does he/she have a history of skin problems? ______________________

Heart

History of circulatory problems? ______________________
Late sleeper or early riser? ______________________
Energy level? ______________________
Pacing / howling? ______________________
Irratic behavior? ______________________

Kidney / Urinary Bladder:

Kidney disorders / blood value changes / dilute urine ______

Cystitis: Straining ______

Blood in urine ______

Crystals ______

Urination: Frequent / infrequent ______

Night time ______

Incontinence? What time of day? ______

Bones / Muscles / Ligaments:

Lameness location: ______

Pain vs. stiffness ______

First occurance: ______

Frequency of recurrences: ______

Duration: ______

Better with motion / rest: ______

Worse with damp weather? ______

Cold weather? ______

Fixed location or moving? ______

Warm to touch or cool? ______

Neurological Issues:

History of seizures? ______

Time of occurrence / recurrence? ______

Skin Issues:

Age when problem was first noticed? ______ Onset sudden or slow? ______

Is there a seasonal influence? No ______ Spring ______ Summer ______ Fall ______ Winter ______

Where on the body did the problem begin? ______

What did it look like? ______

Does he/she itch? ______ When? Constant / Sporadic / Night

Is there any exposure to other animals? (your own, neighbors, etc) ______

Do other animals or people in the household have skin problems? Rash? ______

Describe his/her indoor environment, time (%) ______

Describe his/her outdoor environment, time (%) ______

Is yard fenced or runs free? ______

What does he/she sleep on? ______

What topical treatments have been used? ______

Were they successful? ______

What oral or injectable treatments have been used? ______

Were they successful? ______

Do you have any thoughts as to the cause? ______

What makes it worse? ______

What makes it better? ______

When was the last time you saw fleas on any of your pets? ______

Describe the type of flea control used (topical, pill, etc. , include brand name)?

______

Date, duration of last estrus if still an intact female: ______