**TCVM Patient Intake Form**

Date_____

Client Name _____Patient _____

Diet _____

Medications _____

Supplements _____

Primary Reason for Visit

*(Please list name of referring veterinarian and any treatments/tests that have been done.)*

_____

_____

_____

Is your pet *(check whatever applies)*:

Outgoing/curious/friendly _____
Shy/nervous _____
Defensive/protective _____
Calm/even-tempered _____
Hyperactive/excitable _____

Does your pet prefer:

Cool areas/sleeps on bare floor _____
Warm areas/sleeps with blanket _____

Do you notice any changes in their condition at different times of day?

Worse: Morning _____ Evening _____
Afternoon _____ Late night _____

Do you notice any changes in their condition at different times of the year?

Worse: Summer _____ Winter _____
Fall _____ Spring _____

How is your pet's overall energy level on a scale of 1-10? _____ 1 (sluggish)---10 (hyperactive)

Does your pet eat “human” food? Yes _____ No _____

Does your pet have food sensitivites/intolerances/allergies?

Yes _____ No _____ Don't know _____

Is your pet willing to take medication (easy to give medication to)?

Yes _____ No _____ Don't know _____