



HOLISTIC INTAKE QUESTIONNAIRE

Client Name: _____ Date: _____

Patient Name: _____ Date of Birth: _____ Species: _____

Breed: _____ Color/Markings: _____

Male

Female

Neutered

Spayed

Chief Complaint:

Previous Medical History:

Current Medications and supplements, including dosage:

Any history of food or drug sensitivity?

Yes

No

If so, how?

Current diet:

Does weather, season or time of day affect the symptoms of the main complaint?

Yes

No

If so, please describe:

Describe your pet's personality and how they interact with other animals or people:

Does your pet have any fears or phobias?

Yes

No

If so, please describe:

Has your pet had any litters? If so, how many? _____

Date of spay or neuter surgery: _____

History of any other surgeries or trauma? _____

Vaccine History:

Canine

DAP/DHPPL/DA2PP _____ Last booster _____

Rabies 1 year _____ Rabies 3 year _____ Bordetella _____

Leptospirosis _____ Lyme _____ Canine Influenza _____

Feline

FVRCP/HCP _____ Last booster _____ FeLV/FIV Test _____

Rabies 1 year _____ Rabies 3 year _____ FeLV _____

Any vaccine reactions? If so, please describe: _____

Review of Symptoms:

1.) Gastrointestinal tract:

Flatus	YES	NO
Constipation	YES	NO
Vomiting	YES	NO
Diarrhea	YES	NO
Mucus on Stool	YES	NO
Burping	YES	NO
Borborygmi (noisy intestines)	YES	NO
Incomplete Bowel Movements	YES	NO
Straining to defecate	YES	NO
Fecal Incontinence	YES	NO

2.) Respiratory:

Coughing	YES	NO
Sneezing	YES	NO
Reverse sneezing	YES	NO
Wheezing	YES	NO
Abnormal breathing	YES	NO
Panting excessively	YES	NO
Snoring	YES	NO

3.) Cardiovascular:

Poor stamina	YES	NO
Heart murmur	YES	NO
Other known heart condition	YES	NO

If yes, Please describe: _____

4.) Musculoskeletal:

Stiffness	YES	NO
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If so, where? _____

Soreness	YES	NO
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If so, where? _____

Difficulty getting up or jumping	YES	NO
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Worse or better with activity? _____

Muscle wasting	YES	NO
Abnormal gait	YES	NO

Worse or better with rest? _____

5.) Integument/Skin:

Dandruff	YES	NO
Rash	YES	NO
Pruritis (itching)	YES	NO
Oiliness	YES	NO
Hair Loss	YES	NO
Wounds with discharge	YES	NO
Hot spots	YES	NO
Frequent anal gland issues	YES	NO
Location of any lesions:		

6.) Urologic:

Urinary incontinence	YES	NO
Straining to urinate	YES	NO
Cystitis (infection)	YES	NO
Increased urination	YES	NO
Malodorous urine	YES	NO
Color of urine	Dark	Light
Discharge from prepuce or vagina	YES	NO

7.) Head, ears, eyes, nose, throat:

Loss of vision	YES	NO	
Cloudiness of lens	YES	NO	
Loss of hearing	YES	NO	
Discharge from eyes	YES	NO	
If so, which eye?	Left	Right	Both
Ear infection	YES	NO	
If so, which ear?	Left	Right	Both
Halitosis	YES	NO	
Eye lesions	YES	NO	
Oral lesions	YES	NO	
Gingivitis	YES	NO	
Bad dental disease	YES	NO	
Date of last dental:	_____		

8.) Neurological

Seizures	YES	NO
Head tilt	YES	NO
Incoordination	YES	NO
Dragging limb(s)	YES	NO

9.) General physical signs:

Please describe your pet's characteristics with the following:

- Appetite

- Thirst

- Temperature preference (i.e. seeks cool or warm areas)

- Temperature at various places of the body

- Sleep signs (i.e. restlessness, dream filled, deep, falls asleep easily)

- Energy level in morning vs. afternoon vs. evening

If there is any other pertinent information, please list here:

The Whole Pet Vet Hospital and Wellness Center provides comprehensive veterinary healthcare with an integrative approach. We offer traditional/western diagnostics and treatments as well as holistic therapies including acupuncture, chiropractic, herbal medicine and nutritional counseling.

Signature: _____ Date: _____