

This form helps us prepare for your appointment and customize care for your pet. Please fill out to the best of your ability and return (along with full medical records) to wholistichousecalls@gmail.com a minimum of 2 business days before your scheduled visit.

Caregiver Name and Address:

Who is your primary vet? Were you referred by anyone?

Pet Name:

Pet Age:

Pet Breed:

Pet Sex:

How long have you had your pet?

Please list any back history prior to you obtaining pet (where pet came from, any info on prior illnesses or injuries).

Please describe your primary concerns for seeking holistic care?

Please describe your goals for your pet?

Diet, please include everything your pet eats including treats, snacks, and chews. Please include quantities and when in the day you are feeding.

Please list any known food sensitivities:

Medications or supplements: Please include brand, strength, quantity, frequency, and how long pet has been taking. This includes routine preventatives.

Attitude/Spirit, please circle: Strong Weak Bright Depressed

Voice, please circle: Loud Quiet

Temperature Preferences, please circle: Prefers warmth/sun Prefers cool/shade Neutral

Sleep Habits: Increased frequency Decreased frequency Paces at night Prefers soft bed, Prefers hard surface Sleeps curled up Sleeps stretched out Heavy sleeper
 Light sleeper with frequent dreaming Normal

Eyes, please circle: Weepy Red Tear Staining Vision changes Previously diagnosed eye disease
Normal

Ears: Deafness Odor Itchy Previously diagnosed ear infections Normal

Mouth, please circle: Bad Breath Inflamed gums Oral sores Oral masses
Normal

Skin, please circle: Itchy (please list places itchy, how long has been present, and grade on scale of 1/10 with 1 being mildest and 10 most severe. If seasonal please list when its worst)

Masses Dandruff/flaky skin Hairloss Greasy Odor Redness

Gastrointestinal:

Appetite, please circle: Increased Decreased Skipped meals Picky eater Eats small amounts at a time Difficulty chewing Changes in swallowing No changes

Stool, please circle: Increased frequency Decreased frequency soft/runny mucous present blood present foul smelling stool dry or hard difficulty passing stool chronic diarrhea undigested food in stool fecal incontinence

Vomiting, Please circle: Yes or No
Vomits food: list how often
Vomits yellow bile: list how often
Vomits foam/fluid: list how often

Body condition: Have you noticed your pet losing weight? Gaining weight? Generally difficult to keep weight on? Or prone to obesity?

Gas: Yes or No

Burping/belching: Yes or No

Excessive drooling present: Yes or No

Lip licking/lipsmacking present: Yes or No

Urinary:

Thirst: Increased Decreased No change

Urination: Increased Decreased painful urination Inappropriate urination Urinary leakage

Previously diagnosed urinary tract infections/crystals/stones No change

Respiratory:

Cough, please circle and list when first noticed:

 Dry cough Wet cough Worse at night Worse with excitement

Sneezing, Please circle and list when first noted:
Frequent sneezing Clear nasal discharge Thick nasal discharge Sounds congested

Normal

Breathing changes, Please circle:
Increased panting previously diagnosed respiratory disease wheezing Normal

Neurological:

Have you noticed any seizures or tremors?

Does your pet seem uncoordinated?

Mobility:
Limping/lameness/stiffness/or soreness: Yes or No

If yes, please circle
Intermittent Worse after exercise Worse after rest Worse in cold Worse with heat

Likes massage Painful to touch

 Difficulty going up stairs Difficulty moving down stairs Slips on hard surfaces

Difficulty standing up Difficulty laying down

Noticed all the time

Please list any things you have tried to improve mobility? What has helped, what has not helped?

Please list if any xrays or advanced imaging has been performed, and date: please provide records.

Please list exercise and activities your pet engages in on an average week:

Behavior: Please circle any characteristics that describe your pet.

Anxious Fearful Separation anxiety Destructive behavior

Abnormal activity ex. Overgrooming, eating abnormal things

Doesn’t like dogs Doesn’t like cats Protective of me or another family member

Fearful of loud noises (storms, fireworks)