Holistic Questionnaire

Pet Name ____________________________________ Date _________________

Client Name __________________________________ File number ___________

Breed _________________ Date of Birth _________________ Sex ___________

Presenting Complaint ____

Diagnosis _______________________________ Date of Onset __________________

Progression ____

____

Current Medications (include dose & duration)

____

____

Current Supplements (include dose & duration)

____

____

General Behavior

Seeks / Preference - Heat O Cold O No Difference O

Activity - Normal O Decreased O Inactive O Hyperactive O

Sleep patterns – Restful O Excess O Disturbed/Restless O Dreams O

Interactions (people) – Normal O Aggressive O Avoidance O Fearful O

Interactions (animals) – Normal O Aggressive O Avoidance O Fearful O

Vaccination History

Date of Last Vaccination ___________

Which Vaccines ____

Vaccine Reaction or Side Effects ? Yes No

If so, Describe ____

Vaccine Titers – Yes No Which Ones ? ______________________________

If so, when ? _________________ Results ______________________________

Patient ________________________ Client ________________________ Date _______

Dermatologic Condition

Hair Coat - Normal O Thinning O Dry O Oily/Greasy O Dandruff Flaking O

Duration? ____________________

Describe amount / area ____

Skin - Normal O Dry O Scaly O Itchy O Other _____________

Duration? ____________________

Describe amount / area ____

Skin Lesions / Sores? Yes – No Location ______________________________

Appear as … Rash O Redness O Discoloration O Discharge O

Describe ____

Musculoskeletal History

Body Weight ___________ Normal O Lean O Thin O Overweight O Obese O

Muscle Tone - Normal O Weak O Tense O

What region / area? ____

Stiffness = Acute / Chronic / None

Location: Front Leg (L – R) Hind Leg (L – R)

Back (upper, middle, lower) Neck O Tail O

Worse with Dampness O Heat O Cold O

Worse upon Lying down O Exercise O Overexertion O

Pain = Acute / Chronic / None Better with = Movement / Rest / Nothing

Describe ____

Immune System History

Allergy Type ____________________ Duration _________________

Describe ____

____

Frequent Infections? Yes – No Where? _______________________________

Other Comments ____

Patient ________________________ Client ________________________ Date _______

Respiratory History

Breathing – Normal O Labored O Shallow O Congested O

Cough ________ Sneeze _________ Wheeze __________ Gagging __________

Duration ______________________ Frequency ___________________________

Nasal Discharge - Yes No

Color _________________ Consistency __________________________

Amount _______________ Character ____________________________

Describe ____

Digestive History

Diet ______________________________________ Since When? ____________

Amount Fed? __________________ Amount Eaten? ________________

Other food eaten ____

Appetite Normal O Ravenous O Decreased O None O

Accepts Treats ? Yes No How often given? ______________________

List Treats or Snacks Fed _____________________________________

Thirst Normal O Increased O Decreased O

Water intake ____________oz Other Fluid Intake ______________

Describe changes & severity _____________________________________

Bowel Movement

Stool Amount ______________________ Frequency _______________

Character – Normal O Loose O Diarrhea O Constipated O

Color ___________________ Duration of change _____________

Fecal Analysis Results ____

Vomiting ? Yes - No

When - Sporadic O After Meal O After eating Grass O After Meds O

Frequency ____________________ Amount _______________________

Appearance ____________________ When did it start? ______________

Patient ________________________ Client ________________________ Date _______

Urinary Tract History

Urine Amount ___________________ Urine Frequency _________________

Difficulty Urination None O Straining O Dribbles O

Urine Color ________________ Character – Clear O Cloudy O

Urinalysis Results ____

Reproductive System

Neutered? Yes – No

If so, When? _________________________________

If not, bred? Y – N Successful Litter? Y – N When? ___________

Genital Discharge? Yes – No Describe _______________________

Other Comments ____

Nervous System

Balancing Issues? Stumbles - unsteady on feet – circling - falls to side (L – R)

Head Tilt (L – R) Duration _____________ Progression ______________________

Headache? Avoids light - Squints eyes - Resists petting of head - Eating problems

Twitching? What part ____________ Duration ___________ Progression _________

Seizure? When _________________ Severity ______________________________

Circumstances ____

Describe ____

Veterinary History

Primary Veterinarian ____

Referring Veterinary Hospital____

Phone ___________________________ Fax ___________________________

Previous records requested? Yes – No

Sent to Ness Exotic Wellness Center? Yes – No when rcvd? _______________

Blood Work? Yes - No Radiographs? Yes – No

Other Tests ____