PET
MEDICAL
CENTER

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Acupuncture / Traditional Chinese Medicine Appointment History Questionnaire

Please return this questionnaire and your pet's medical records (including x-rays and doctor's notes) at least 2 days prior to their appointment.

PATIENT NAME:_____ OWNER NAME:_____ DATE: _____

I. What is your patient's main reason for seeking/needing acupuncture?

a. Health Problem(s), describe:_____

b. General Wellness: _____

II. If your pet was treated previously for this problem, please answer the following questions:

• What diagnostics have been done and what were results? (ex. Bloodwork, X-rays – if they were not done here, please have the records transferred)

• What treatments were utilized?

• Did the pet show any improvement? If so, please describe:

• Since your pet's last veterinary visit, is he/she: the same / better / worse

III. Please list to your best ability:

o CURRENT MEDICATIONS:

o CURRENT HERBS AND/OR SUPPLEMENTS:

o CURRENT DIET:

o CURRENT EXERCISE REGIMEN:

IV. Traditional Chinese Medicine (TCM) history:
(in each section, please answer or circle all that apply)
Energy and Well-Being:

• Energy level in general:	normal / reduced / increased
• Energy is highest:	morning / afternoon / night / consistent
• Attitude/mood is best:	morning / afternoon / evening / night / consistent
• My pet is:	Outgoing / Shy / Aggressive
• My pet is:	Happy / Content / Restless / Crabby / Depressed
• My pet prefers:	to be cool / to be warm / does not have a preference
• Sleep:	normal / decreased / increased/restless at night
• Dreams:	none / vocalization / running

Mobility

• Mobility level: normal / reduced / increased
• Mobility is best: morning / afternoon / evening / night / consistent
• My pet has a specific area that is weak or lame: yes / no

If "Yes," please circle all that apply:

Front right leg/Front left leg / Back right leg/Back left leg

Pain

My pet is in pain: Yes / No **If Yes, How long**? _____

If you answered "Yes," please complete the following regarding your pet's pain:

- Pain is ___/10 with 10 being the worst
- Is the pain in a specific area? No / Yes, where?:_____
- Better / worse after rest
- Better / worse after exercise
- How does weather / temperature affect your pet's pain?_____
- Better in morning / better in afternoon/ better in evening / no time difference

Nutrition/Digestion/ Urinary:

• Appetite: normal / increased / decreased
• My pet: loves to eat / is not food motivated / is picky
• Vomiting: none / occasional / a couple of times per week / often / other:

o **If vomiting is a regular occurrence, please describe** when it happens and what it looks like:

_____

• Stools – normal / soft/ diarrhea / hard and dry /constipation / incontinent

o There is blood / mucous in the stool
o Odor of stool – normal / strong / no odor
o Does your pet have gas? Yes / No

• Thirst: normal / increased / decreased
• Water intake: Frequent small sips/large amounts at one time/ moderate
• Urine: normal/increased/decreased / Incontinent / Straining/ Vocalizes

o Color of urine? Normal / clear / dark yellow
o Odor of urine? Normal / no odor / strong odor

Skin

• My pet has: Brittle nails / dry pads / dry skin with large flakes / dry skin with small flakes
• Is your pet itchy? No / Yes
• **If "Yes**" please circle all that apply: sometimes / during day / at night / all the time
• Has your pet's hair coat changed? No / Yes, describe:_____

Reproduction:

• fertile / infertile / not applicable
• Describe any reproduction problems your pet has had: _____

Respiration/breathing:

• normal / coughs / has had a change in breathing, describe: _____
• My pet's voice or noises that he/she makes are: the same / have changed, describe:

_____

Is there anything else we should know about your pet's health or emotional history?