

ALL ABOUT PETS, INC.
VETERINARY SERVICES & BOARDING KENNELS
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CONVENTIONAL CARE, ACUPUNCTURE, HOMEOPATHY, VETERINARY ORTHOPEDIC
MANIPULATION, & NUTRITIONAL THERAPY.

Integrative Medicine: HEALTH HISTORY

Patient Name: _____ Age: _____ Sex: _____ Altered: _____ Breed: _____
Color: _____ Weight: _____

PERSONAL HISTORY – Getting to know you and your companion

When did your pet join your family? _____
Under what circumstances? _____

What age was your pet? _____
How would you describe his/her state of health at that time? _____

How would you describe his/her personality when acquired? _____

Has the personality or state of health changed since then? How? _____

Can you describe the quality of the relationship you have with your pet? _____

How much time do you typically spend together and what is your favorite activity? _____

GENERAL HEALTH REVIEW – Describe the following about your pet:

Date of last blood work: _____ X-ray _____ (Please Bring Copies)

Personality: (circle) sweet happy temperamental aloof quiet loud
dominant passive excited snippy sad anxious calm fearful yappy

Other: _____

Things he/she really enjoys: _____

Things he/she really hates or fears: _____

Anxieties or stresses _____

Relaxes easily? _____

Quality and length of sleep _____

Wakes refreshed? _____

Prefers warmth or cold? In what way? _____

Does he/she like fresh air and sunshine? _____

Likes soft(eg. blankets) or hard (eg. tile floors) places to rest? _____

ACTIVITY LEVEL

How active is your pet? _____

Describe level of energy _____

Does he/she tire easily? If so, do they pant, have problems breathing, etc.? _____

NUTRITION

What type of food do you feed? _____

Previous foods (if any)? _____

Any homecooked food? _____

Additional foods or treats? How many and how often? _____

Food preferences? _____

Temperature of food and water preferred? _____

Level of appetite? _____

Amount of water intake (thirsty or thirstless)? _____

HISTORY OF HEALTH CONCERNS

Earliest symptoms you remember your pet experiencing _____

When noticed? Duration? _____

Medications given _____

Response to medications _____

Events preceding or surrounding the onset of symptoms _____

Vaccinations preceding symptoms? _____

If so, what type and when? _____

Specific diagnosis _____

Additional symptoms and diagnoses (please list in chronological order with the information asked above)

Tendency towards illness? _____

Chronic disease tendency or problems _____

Heals quickly or slowly from illness _____

CURRENT HEALTH CONCERNS

Current medications: What and why? _____

Vitamins and/or supplements: What and why? _____

ARE THERE ANY TYPES OF MEDICAL TREATMENT THAT YOU ESPECIALLY WANT TO CONSIDER? (e.g., acupuncture, herbs, supplements, massage, Traditional Chinese Medicine, homeopathy, etc.) _____

WHAT ARE YOUR GENERAL EXPECTATIONS FOR YOUR PET'S CONDITION? (cure, better quality of life, increased longevity, fewer medications, etc.) _____
