

EVERHART

-- VETERINARY HOSPITAL --

4005 Ritchie Highway
Baltimore, MD 21225
410-355-3131



EVERHART

----- WELLPET CENTER -----

8482 Fort Smallwood Rd
Pasadena, MD 21122
410-793-7670

Integrative Medicine Questionnaire

Name of Owner:

Address:

Phone:

Email:

Patient Name:

Species/Breed:

Sex:

Age:

Weight:

Best Time and Way to Reach You: _____

Referring/Regular Veterinarian if different then Everhart: _____

Please help us provide your pet with a complete evaluation by taking the time to fill out this questionnaire carefully. If there is anything you wish to bring to my attention, which is not asked on this form, please note it in the comments section.

Presenting Complaint:

What is the main problem you would like to help your pet with:

How long ago did this problem begin (be as specific as possible)?

To what extent does this problem interfere with your pet's daily activities?

What diagnosis have you been given for this problem? What kind of treatments have you tried?

List current medications/herbals/supplements your pet is on including Heartworm/Flea

Prevention: _____

Current Status:

Name your pet's diet (type of food, how much given, how often, any treats):

- Lively Very Friendly Craves Attention Assertive Easily Angered
- Alpha Laid back Motherly Worries Shy
- Fearful Careful Jealous Aloof Disciplined
- Confident Pushy Easy to Excite Bossy Sociable
- Timid Irritable Vocal Insecure Dislikes Strangers
- Mellow Has Patience Prone to Anxiety Slow to Excite
- Prefers Shade Prefers Cool Prefers Warmth Prefers Sun Excessive Panting
- Prefers Outdoors Prefers Indoors Problems change with Weather or are Seasonal
- Other _____

Describe your animal in 3 words: _____

List any changes in your pet's environment that may have caused him/her stress in the last 6 months: _____

Medical History

Past Significant Illnesses:

- Cancer Diabetes Heart Disease Thyroid Disease
- Seizures Kidney Disease Liver Disease Behavioral Problems
- Other _____

Surgeries: _____

Significant Trauma: _____

Allergies: _____

Additional Medications/Herbals/Supplements taken over last 3 months: _____

Frequency of vaccines: _____

Any negative reactions to medications/vaccines: _____

Please check if your pet has had any of these problems/symptoms in the last 12 months:

Neurological/Behavior Problems

- | | | |
|-----------------------------------|--|---|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Lack of Coordination |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Bad Temper | <input type="checkbox"/> Behavior Changes |
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Good Attitude | <input type="checkbox"/> Easily Susceptible to stress |

Any other Neurological or Behavioral Problems?

Head, Ears, Eyes, Nose, and Throat

- | | | |
|---|--|---|
| <input type="checkbox"/> Poor Vision | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Runny Eyes |
| <input type="checkbox"/> Itchy Eyes | <input type="checkbox"/> Dry Eyes | <input type="checkbox"/> Ear Discharge |
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Itchy ears | <input type="checkbox"/> Nose Bleeds |
| <input type="checkbox"/> Color change on Nose | <input type="checkbox"/> Sores on Lips/Tongue | <input type="checkbox"/> Teeth Break Easily |
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Grinding Teeth | <input type="checkbox"/> Tartar |
| <input type="checkbox"/> Collapsing Trachea | <input type="checkbox"/> Head Always Warm to Touch | |

Any other Head or Neck problems?

Gastrointestinal

- | | | |
|---|---|--|
| <input type="checkbox"/> Ravenous Appetite | <input type="checkbox"/> Finicky Appetite | <input type="checkbox"/> Change in Appetite |
| <input type="checkbox"/> Increased Thirst | <input type="checkbox"/> Decreased Thirst | <input type="checkbox"/> Change in Thirst |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea/Loose Stool | <input type="checkbox"/> Dry Stool <input type="checkbox"/> Hard Stool |
| <input type="checkbox"/> Gas | <input type="checkbox"/> Belching/Regurgitation | <input type="checkbox"/> Black Stools |
| <input type="checkbox"/> Blood in Stools | <input type="checkbox"/> Smelly Stool | <input type="checkbox"/> Undigested Food in Stool |
| <input type="checkbox"/> Fecal Incontinence | <input type="checkbox"/> Gassy | <input type="checkbox"/> Worms |
| <input type="checkbox"/> Hair Balls | <input type="checkbox"/> Food Cravings _____ | |

Any other Stomach or Intestinal Problems?

Genito-Urinary

- | | | |
|---|---|---|
| <input type="checkbox"/> Inappropriate Urination | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Blood in Urine |
| <input type="checkbox"/> Urinary Incontinence/Leakage | <input type="checkbox"/> Long Urine Stream | <input type="checkbox"/> Smelly Urine |
| <input type="checkbox"/> Kidney/Bladder Stones | <input type="checkbox"/> Crystals in Urine | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Reproductive disease | <input type="checkbox"/> Change in Color or Odor of Urine | |

Any other problems with your pet's urinary or reproductive system?

Please note if your pet had any known abnormal heat cycles, abnormal litters, prostate or testicular disease prior to being spayed or neutered.

Respiratory

- | | | |
|--|---|---|
| <input type="checkbox"/> Dry Cough | <input type="checkbox"/> Wet Cough | <input type="checkbox"/> Loud cough |
| <input type="checkbox"/> Weak Cough | <input type="checkbox"/> Cough worse during Day | <input type="checkbox"/> cough Worse During Night |
| <input type="checkbox"/> Coughing Blood | <input type="checkbox"/> Asthma | |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Difficult Breathing | <input type="checkbox"/> Cough after Exercise |
| <input type="checkbox"/> Discharge from Nose | <input type="checkbox"/> Production of Phlegm | |

Any other lung problems?

Cardiovascular

- | | | |
|--|--|-----------------------------------|
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Swelling of paws/legs | <input type="checkbox"/> Tires Easily | <input type="checkbox"/> Edema |

Any other heart or blood problems?

Musculoskeletal

- | | | |
|---|---|--|
| <input type="checkbox"/> Likes Being Massaged | <input type="checkbox"/> Moves from touch/massage | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Shoulder Pain |
| <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Muscle Weakness | <input type="checkbox"/> Stiff |
| <input type="checkbox"/> Limping | <input type="checkbox"/> Difficulty getting up | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Keeps tail tucked in | | |

Any other joint, bone or muscle problems?

If stiff or experiencing muscle, how long has your pet experienced this problem? Is Stiffness or

Pain worse: Day? Night? After Rest? After Activity?
 When it is Cold out? Hot out? Damp out?

Skin and Hair

- | | | |
|---------------------------------------|--------------------------------------|---|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Hives | <input type="checkbox"/> Itching |
| <input type="checkbox"/> Pimples | <input type="checkbox"/> Dandruff | <input type="checkbox"/> Loss of Hair |
| <input type="checkbox"/> Warts | <input type="checkbox"/> Dry Coat | <input type="checkbox"/> Odor to Skin/Fur |
| <input type="checkbox"/> Flea Allergy | <input type="checkbox"/> Greasy Coat | <input type="checkbox"/> Change in Coat |

Any other Skin or Coat problems?

General

- | | | |
|--|--|--|
| <input type="checkbox"/> Change in Bark/Meow | <input type="checkbox"/> Loud Voice | <input type="checkbox"/> Weak Voice |
| <input type="checkbox"/> Poor Sleeping | <input type="checkbox"/> Sleeps too much | <input type="checkbox"/> Sleeps After Eating |
| <input type="checkbox"/> Prefers Hard Bed (ie Floor) | <input type="checkbox"/> Prefers Soft Bed | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Localized Weakness | <input type="checkbox"/> Poor Balance | <input type="checkbox"/> Bleeds/Bruises Easily |
| <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Dreams a lot |
| <input type="checkbox"/> Vocalizes when Dreaming | <input type="checkbox"/> Paddles or Jerks muscles while Dreaming | |
| <input type="checkbox"/> Energy Drop (What time of Day?) _____ | | |

Comments or other problems you would like to discuss? Please use the back for more room:

Authorization to Perform Alternative Therapy

I understand that the following are considered alternative/integrative forms of therapy and investigative by mainstream medicine:

-Acupuncture: including acupuncture, aquapuncture, electroacupuncture, laser therapy, moxabustion, etc.

-Herbal Therapy: including oral, topical, TCM and western formulations and nutritional supplements.

-Skeletal Manipulations

-Homeopathy

In addition, I understand all medicine, both alternative and conventional, run some inherent risk.

I authorize Dr. Alison Key to perform alternative/integrative therapy on my pet. I acknowledge that no guarantee or assurance has been made to me as to the results that may be obtained.

Signature: _____

Date: _____