Driftway Animal Hospital
HOLISTIC CONSULT QUESTIONNAIRE

53 New Driftway
Scituate, MA 02040
(781)-545-0952 Phone
(781)-545-6763 Fax

PLEASE FILL OUT PRIOR TO YOUR VISIT AND BRING (OR FAX) THIS FORM FOR YOUR INITIAL CONSULTATION

Name Last_____

First_____

Address _____

_____

Best phone number and time to contact you about your pet:

Your Pet's Name_____

Breed_____

Species (please circle): Dog Cat

Date of Birth: _____

Sex: Male Female **Neutered:** Yes No

If yes, at what age_____

Why are you seeking holistic care for your pet?

Is there a particular modality that you are interested in?
(Acupuncture, Chiropractic, Herbal Medicine, Nutritional Supplements, etc.)

CURRENT HEALTH CONCERNS

Describe your concerns with your pet's health.
(List from most to least concerning. Please note when the problem was first noticed)

How has the problem been treated in the past?
(Please list all medications, supplements, surgeries, treatments)

Is your pet taking any medication or supplements at this time?
(Please list dosage and frequency)

YOUR PET'S LIFESTYLE

How long have you owned your pet?

Has your pet ever been used for breeding?

What form of exercise does your pet get and how often?

Is your pet mostly indoors or outdoors?

How many people live in the household? Describe your pet's interaction with them.

How many other pets live in the household? Describe your pet's interaction with them.

Does your pet perform any special function? (Agility, Therapy Dog, Hunting, etc.)

Are there any particular stressors in your pet's environment? (Physical and/or Emotional)

Does your pet have any fears/phobias? (Men, Women, Children, Dogs, Cats, Storms, etc?)

Does your pet have a temperature preference? Does he or she seek out warm or cool areas to lie?

Does your pet sleep well throughout the night? Describe your pet's sleeping habits.

What do you feed your pet? Please be specific.

How would you describe your pet's appetite: (please circle)
Ravenous Normal Decreased

How would you describe your pet's thirst: (please circle)
Increased Normal Decreased

Please circle any of the following personality traits that your pet exhibits:

Likes to be the center of attention
Hyperactive
Extroverted
Easily excited
Prone to separation anxiety
Very friendly and sociable
Mellow and calm
Aloof
Shy and fearful
Noise sensitive
Storm phobia
Might bite or urinate if startled
Dominant
Aggressive (Please describe below and be specific [with people, other animals, food, etc.])

PHYSICAL CONDITION

Does your pet see well? Any discharge, redness or other eye abnormalities?

Does your pet hear well? Any discharge, odor, or itchiness of the ears?

Does your pet have a history of coughing, sneezing, nasal discharge, excessive panting?

How often does your pet defecate? Is the stool a normal color and well formed?

How often does your pet urinate? Does your pet ever strain to urinate or dribble/leak urine? Is the urine a normal color?

Does your pet have trouble with stairs, walking, running, getting up or lying down? Please describe

Describe the condition of your pet's skin and coat. Does he or she shed excessively, have flaky skin, greasy skin, hair loss, or excessive itching?

MEDICAL HISTORY

Please have your pet's medical history (including proof of rabies vaccine) faxed to our office prior to your appointment.

This will give Dr. Burke the opportunity to review the history before you arrive.

Be prepared to spend 40-60 minutes with the doctor on your pet's first holistic evaluation.