

**ALTERNATIVE VETERINARY HOSPITAL
TCM CONSULT QUESTIONNAIRE**

Date: _____

Client's Name: _____

Pet's Name: _____

Reason for today's visit: _____

Best phone number to reach you: _____

Are **you** allergic to any medications? Yes No
If yes, describe: _____

Are **you** Vegan? Yes No

Do you walk your dog on a leash to potty or just let the dog go outside? Leash Outside

Do you have stairs @ your house? Yes No

Does your pet have difficulty doing anything now that it used to do with no problem? Yes No
If yes, describe: _____

Is your pet current on vaccines? Yes No

Has your pet ever had a vaccine reaction? Yes No

What is your pet's favorite table food? _____

Does your pet have accidents in the house? Yes No
If yes, urine or feces? Urine Feces
Is this a new/old problem? New Old
How often? _____

Does your pet react to loud noises or thunderstorms? Yes No

Where does your pet sleep? _____

Has your pet ever had a seizure? Yes No
If yes, when? _____

Has your pet ever bitten anyone? Yes No
If yes, who? _____

When your pet goes outside, does it seek to lay in the sun or shade? Sun Shade

What do you feed your pet? _____

Does your pet cry or grunt when you pick it up? Yes No

Does your pet cry out/vocalize/twitch in its sleep? Yes No

Does your pet dislike being touched anywhere on its body? Yes No
If yes, describe: _____

Does your pet like to be combed or massaged?		Yes	No		
What do your pet's stools look like?	Logs	Rocks	Soft		
Does your pet vomit?		Yes	No		
If yes, how frequently:	_____				
Does your pet ever have diarrhea?		Yes	No		
If yes, how frequently:	_____				
Is your pet very thirsty?		Yes	No		
Where does your pet drink water?	_____				
Does your pet get overheated quickly/easily?		Yes	No		
Is your pet a picky eater?		Yes	No		
If yes, describe:	_____				
Does your pet have a good appetite & cleans its bowl when food is presented?		Yes	No		
Does your pet eat unusual objects or stool?		Yes	No		
If yes, describe:	_____				
How many other pets in household?	_____ Cats	_____ Dogs			
Has your pet been spayed/neutered?		Yes	No		
How old was your pet when it was spayed/neutered?	_____				
What medications/supplements are you currently giving to your pet?	_____				

Is your pet urinating more frequently or larger amounts than in the past?		Yes	No		
Does your pet seem to have loss of vision or hearing or seemed confused?		Yes	No		
Does your pet pace & pant at night rather than just going to bed?		Yes	No		
Does your pet scoot its bottom?		Yes	No		
Is your pet:	Happy	Timid	Aggressive	Dominant	Submissive
(Please Circle)	Outgoing	Fearless	Fearful	Anxious	Grieving
Does your pet have an unusual odor?		Yes	No		
If yes, describe:	_____				
Does your pet:	Snore	Snort	Sneeze	Cough	Reverse Sneeze
(Please Circle)					
Does this occur seasonally?					Yes No
When weather changes?					Yes No
Is your pet:	High Energy	Moderate Energy	Low Energy		
(Please Circle)					

Has there been a change recently in activity? If yes, describe: _____	Yes	No
Does your pet have pain? If yes, where: _____	Yes	No
Does your pet lick/chew its feet?	Yes	No
Does your pet seem unsteady on its feet? If yes, describe: _____	Yes	No
Does your pet limp or carry a leg?	Yes	No
Does your pet drag a rear leg?	Yes	No
Does your pet have any difficulty chewing its food?	Yes	No
Does your pet refuse to eat food or treats?	Yes	No
Does your pet scratch its ears?	Yes	No
Has your pet had any chronic condition(s)? If yes, describe: _____	Yes	No
Has your pet ever lost its voice?	Yes	No
How often does your pet have a bowel movement? _____		
What time of day? _____		
Does it go all at once or in pieces? _____		
Is there undigested food or grass in it? _____		
What is the color of the stool? _____		
Is it greasy?	Yes	No
Is your pet tired after it eats?	Yes	No
Has your pet recently lost weight?	Yes	No
Has your pet recently gained weight?	Yes	No
Does your pet itch?	Yes	No
Have you ever tried to feed raw food to your pet? If yes, what did your pet like? _____	Yes	No