DATE:___________________

NEW PATIENT MEDICAL QUESTIONNAIRE

NAME:____TELEPHONE:______________________
EMAIL:___________________________________ALT. TELEPHONE:______________________
ADDRESS:____

PATIENT INFORMATION:
NAME:____________________________DOB:_________F/S/M/N BREED:_________________
WEIGHT:_______# DATE OF LAST VACCINES:______________
FAMILY VETERINARIAN:____
FAMILY VETERINARIAN CONTACT:____
HOW WERE YOU REFERRED TO MVWC:____

REASON FOR VISIT, please describe:____
____
____
OTHER CURRENT MEDICAL CONCERNS/PROBLEMS:____
____
____
ALLERGIES:____
PREVIOUS ILLNESSES/SURGERIES/INJURIES AND DATES:_________________________________
____
____
CURRENT MEDICATIONS, SUPPLEMENTS, HERBS, ETC. AND DOSAGES:_______________________
____
____
____
DIET: ____
__________________________AMOUNT FED:____________MAIN PROTEIN:______________
NORMAL ACTIVITIES:____

HOME ENVIRONMENT:
NUMBER OF FAMILY MEMBERS (PEOPLE AND PETS):_______________________________________
INTERACTIONS WITH FAMILY:____
____
INTERACTIONS WITH OTHER PEOPLE AND ANIMALS:_______________________________________
____

PET PERSONALITY, please circle all that apply:

- CONFIDENT
- ASSERTIVE
- ATHLETIC
- BOSSY
- BITES
- FEARLESS
- ALPHA ANIMAL
- EXCITABLE
- FRIENDLY
- JOYFUL
- SENSITIVE
- LOVING
- TALKS A LOT
- LAID BACK
- BALANCED
- CARING
- WORRIES
- LIKES TO EAT
- ROTUND
- ORDERLY
- ALOOF
- DISCIPLINED
- STOIC
- DISLIKES TO BE TOUCHED
- CLEANS A LOT
- CAREFUL
- CURIOUS
- FEARFUL
- SHY
- SOLITARY
- SLOW
- SCARES EASILY

PROBLEMS YOUR PET MAY HAVE, please circle all that apply:

- LIGAMENT TEAR
- LIVER
- ANGERS EASILY
- RED EYES
- NAIL PROBLEMS
- ANGERS EASILY
- EAR ISSUES
- SEIZURES
- ALLERGIES /ITCHING
- INCREASED BLOOD PRESSURE
- INSOMNIA
- SEPAR. ANXIETY
- HYPER
- MENTAL ISSUES
- RAPID HEART RATE
- HEART ISSUES
- OCD
- COGNITION
- LOSS OF APPETITE
- CONSTIPA-TION
- DIARRHEA
- VOMITS
- OVEREATS
- MUSCLE LOSS
- WORRIES
- GUM DISEASE
- LIMB WEAKNESS
- ASTHMA
- DRY SKIN
- COUGHS
- SAD
- BREATHING ISSUES
- SINUS/ NOSE PROBLEMS
- TRACHEAL PROBLEMS
- WEAK VOICE
- ARTHRITIS
- WEAK REAR LIMBS
- BONE/BACK ISSUES
- URINARY PROBLEMS
- DEAF
- FERTILITY ISSUES
- HALITOSIS

REPORT ANY CHANGES WITH THE FOLLOWING:
APPETITE:____
THIRST:____
SLEEPING:____
URINATING:____
DEFECATING:____
VOMITING:____
BOWEL HABITS/CONSISTENCY:____
ENERGY LEVEL:____
MOVEMENT:____

If stiff joints, WORSE when, please circle all that apply:

- IN MORNING
- IN EVENING
- AFTER EXERCISE
- BEFORE EXERCISE
- COLD WEATHER
- HOT WEATHER
- DAMP WEATHER

BEHAVIOR CHANGES (PHOBIAS, AGGRESSION, FEARS) :_______________________
____
HAS YOUR PET HAD ACUPUNCTURE BEFORE, if yes, for what conditions:_________
____
WHAT ARE YOUR MAIN GOALS OF TREATMENT:______________________________
____
____
ANY OTHER IMPORTANT INFORMATION NOT COVERED ABOVE:________________
____
____

Thank you for taking the time to fill out this questionnaire before the appointment!