



Integrative Healing Veterinary Clinic & Mobile Services

102 S. Business Plaza
New Bern, NC 28562
Phone: (252) 671-4883
Fax: (252) 638 - 4482

Thank you for choosing Integrative Healing Veterinary Clinic & Mobile Services to treat your pet! Please take a few minutes to complete the following forms and email (integrativehealingvet@gmail.com) or fax (252-638-4482) them back at least 48 hours prior to your appointment. If you need to cancel or reschedule your appointment, please provide at least 48 hours notice to avoid a \$50 late cancellation fee. We look forward to working with you soon!

OWNER INFORMATION:

Owner Name: _____ Spouse/Partner/Other: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Alternate Phone: _____

Email: _____

Primary Veterinarian: _____ Name of Clinic: _____

Veterinarian Phone #: _____

How did you hear about us? _____

Are you okay with Appointment Email Reminders? Yes No

Has your pet previously had: chiropractic (Yes/ No), acupuncture (Yes/ No), massage (Yes/ No)

PET INFORMATION:

Pet's Name: _____ Breed: _____ Color: _____

Age or Date of Birth: _____ Sex: _____ Spayed or Neutered? _____

Pet's Origin (Breeder, rescue, stray, etc.): _____

Pet's Personality: _____

Date of Last Vaccines or Titters: _____ Other Pets in the house?: _____

DIET INFORMATION – Please check one:

Dry: No Yes

Eats Free Choice: No Yes

Canned: No Yes

Set Meal Times: No Yes

Homemade: No Yes

Treats per day: _____

Raw: No Yes

Brand/Types of Treats: _____

If using dry kibble, canned or prepared diet please list the brand here: _____

CURRENT MEDICATIONS - (Including Heartworm and Flea/Tick Preventatives):

Name of Medication:	Dosage and Frequency Given:

CURRENT SUPPLEMENTS/HERBAL FORMULAS:

Name of Supplement:	Dosage and Frequency Given:

PET PREFERENCES – Please check all that apply:

Warmth:		Moist/canned food:	
Cold:		Massage/petting/brushing:	
Hard Surfaces:		Limited touching:	
Soft/Padded Surfaces		Company of People:	
Lounging		Company of Other Animals:	
Active Play:		Prefers Alone Time:	
Dry Food:		Enjoys Children:	

PHOBIAS – Please check all that apply:

Other Animals:	
Thunder :	
General Loud Noises:	
People:	
Certain Objects:	
Other:	

OTHER – Please check one:

Appetite: [] Increased [] Normal [] Decreased
Weight: [] Loss [] Gain [] Stable
Water consumption: [] Increased [] Normal [] Decreased
Bowel movements: [] Normal [] Constipated [] Diarrhea
Urination: [] Normal [] Increased [] Decreased
Seizures: [] No [] Yes

IMPORTANT MEDICAL HISTORY:

Date of Occurrence:	Description of Problem:

KNOWN ALLERGIES OR SENSITIVITIES:

Foods:	
Drugs:	
Environmental:	
Vaccines :	

MAJOR CONCERN/REASON FOR SEEKING INTEGRATIVE TREATMENT:

Issue/Complaint: _____

Beginning Date: _____

RESPONSE TO CURRENT TREATMENTS:

Adverse Effects:	
Partial Response:	
Successful:	
No change Noted :	
Explanation:	

ANY ADDITIONAL COMMENTS/INFORMATION:
