Integrative Healing Veterinary Clinic & Mobile Services
105 Trent Acres Dr.
Pollocksville, NC 28573
Phone: (252) 671-4883
Fax: (252) 638 - 4482

Thank you for choosing Integrative Healing Veterinary Clinic & Mobile Services to treat your horse! 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: _____

Barn Name & Location (if different than Address listed above): Barn: _____

Address: _____City: _____State:_____ Zip: _____

Phone: _____Alternate Phone: _____

Email: _____

Primary Veterinarian: _____Name of Clinic: _____

Veterinarian Phone #:_____Farrier:_____

How did you hear about us? _____

Are you okay with Appointment Email Reminders? _____Yes _____No

Has your horse previously had: chiropractic (__Yes/__No); acupuncture (__Yes/___No), massage (__Yes/___No)

HORSE INFORMATION:

Horse:_____Breed:_____

Age or Date of Birth: _____Sex:_____Color:_____

Horse's Origin (Breeder, Auction, Rescue,etc.):_____

Horse's Personality: _____

Horse's Job/Occupation:_____

Habbits/Vices:_____

Date of Last Teeth Float:_____Dental Abnormalities:_____

Date of Last Deworming & Product Used:_____

Date of Last Vaccines or Titers: _____

Is this horse insured? _____If yes, please provide the name & phone number of insurance company :

_____

DIET INFORMATION:

(include brand, amount, & frequency of feed and hay)

_____

_____

_____

CURRENT MEDICATIONS:

Name of Medication:	Dosage and Frequency Given:

CURRENT SUPPLEMENTS/HERBAL FORMULAS:

Name of Supplement:	Dosage and Frequency Given:

HORSE PREFERENCES – Please check all that apply:

Seeks the Sun:		**Likes Massage:**	
Seeks the Shade:		**Likes Grooming**	
Hard Surfaces:		**Prefers Limited Touching:**	
Soft Surfaces:		**Likes Company of People:**	
Prefers to Relax:		**Likes Company of Other Horses/Animals**	
Prefers to Work:		**Prefers Alone Time:**	
		Enjoys Children:	

PHOBIAS – Please check all that apply:

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

(Include any history of injury, illness, colic, or emotional disturbances. Injuries include falls, lamenesses, wounds, head trauma, foot problems, fractures, and surgery.)

Date of Occurrence:	**Description of Problem:**

KNOWN ALLERGIES OR SENSITIVITIES:

Foods:	
Drugs:	
Environmental:	
Vaccines :	

TRAINING PROBLEMS:

(include stiffness, asymmetries, gaiting abnormalities, bitting problems)

_____

_____

_____

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:

_____

_____