

## Acupuncture Patient Registration

Please complete the following questionnaire as completely as you can.

First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Email: \_\_\_\_\_

Phone: \_\_\_\_\_

Pet's Name: \_\_\_\_\_

How was your pet acquired? \_\_\_\_\_

Describe your pet's typical day:

Please detail your pet's medical history:

Current diet:

Any dietary restrictions?

Can your pet have treats?      Yes      No

Current medications:

Major complaint and what we hope to improve with acupuncture?

**Symptoms**

If they are increased, decreased, or any other comments, please note.

Voice: For Example: Do they sound hoarse or raspy, are less vocal?

Activity Level:

Sleep

Does your pet sleep through the night? Do they wake up at any particular times during the night?

Temperature Preference:

Warm or cool places

Food Intake:

Water Intake:

Stool:

Urination

Vomiting:

Cough:

Stiffness:

Personality:

Please describe their typical personality. Are they very friendly? laid back? nervous etc.?

Has your pet ever received acupuncture before or are you familiar with Eastern Medicine?

Yes      No

Are you interested in exploring herbal medication and food therapy as an adjunctive treatment modality to acupuncture?      Yes      No

How did you hear about us?

My Primary Care Veterinarian

Social Media

Google

Friend/Family Recommendation

Radio Ad

Event

Other