

Date: _____

Client: _____

Homer Veterinary Clinic, PC

Traditional Chinese Veterinary Medicine Small Animal Intake

Patient name _____ Species _____ Breed _____
Weight _____ DOB _____
Sex F SF M MN

Client Address: _____ Telephone(s): _____

Email: _____

Visit Information:

Primary concern: _____

Secondary concerns: _____

Tick which apply most closely to presentation/history:

	<u>Yang (Heat)</u>	<u>Yin (Cold)</u>
Age:	<input type="checkbox"/> Young	<input type="checkbox"/> Old
Disease course:	<input type="checkbox"/> Short, acute	<input type="checkbox"/> Chronic, long
Preference:	<input type="checkbox"/> Shade or cool locations (tile/concrete) (tile, concrete, wood)	<input type="checkbox"/> Sun or warm locations (rugs/bed/soft)
Personality:	<input type="checkbox"/> Hyperactive, outgoing, confident, strong confident (fire, wood)	<input type="checkbox"/> Quiet, timid, less (water, earth)
Diet:	<input type="checkbox"/> Dry food, hot food (chicken, venison) (chicken, venison, lamb)	<input type="checkbox"/> Iced food or drink, cold food (fish/tofu)
Thirst:	<input type="checkbox"/> Drinks a lot/thirsty	<input type="checkbox"/> Reluctant drinker, less thirsty
Appetite:	<input type="checkbox"/> Good or ravenous	<input type="checkbox"/> Good or finicky eater
Stool:	<input type="checkbox"/> Dry or bloody or strong odor	<input type="checkbox"/> Poorly formed to diarrhea
Urination:	<input type="checkbox"/> Short stream or bloody or strong odor	<input type="checkbox"/> Long stream or Incontinent/leaking
Medications:	<input type="checkbox"/> Steroids, yang/qi tonic herbs	<input type="checkbox"/> Antibiotic, heat clearing, Yin herbs
Vaccinations:	<input type="checkbox"/> Acute illness after vaccination	<input type="checkbox"/> Chronic disease Frequent/excess vaccines
Predisposition:	<input type="checkbox"/> Yang Excess, Heat Pattern <input type="checkbox"/> Yin deficiency, Blood Deficiency <input type="checkbox"/> Liver Yang Rising	<input type="checkbox"/> Yang Deficiency, Yin XS <input type="checkbox"/> Cold Pattern, Qi Def <input type="checkbox"/> Qi stagnation, Blood stagnation
Heat Condition:	<input type="checkbox"/> 4 or more yang signs	<input type="checkbox"/> 2 or less Yin signs

	(Excess heat)	(Yin deficient)
Cold condition:	<input type="checkbox"/> 2 or less yang signs	<input type="checkbox"/> 4 or more Yin signs
	(Yang/Qi deficiency)	(Excess cold)
Combination:	<input type="checkbox"/> 3 or more signs	<input type="checkbox"/> 3 or more signs

Personality Assessment: Five Element

Circle characteristics that are noted predominately:

	Wood	Fire	Earth	Metal	Water
Yang/Yin Type:	Yang	Yang	Yin	Yin/Yang	Yin
Interactions:	Aggressive	Very Friendly	Comfortable	Aloof/OK	Timid
Greeting strangers:	Barks or attack	Wags tail	Slow reaction	Does not care	Avoids
Patience:	None	None	Yes	Yes	Yes
Excitability:	Yes	Easily	Slow	No	No
Reactions to Acupx	Cooperative	Very sensitive	No problems	Cooperative	Sensitive
Others:	Irritable	Vocal	Mellow	Loves rules	Insecure

Diet

<input type="checkbox"/> Dry kibble	<input type="checkbox"/> Canned	<input type="checkbox"/> Home-cooked	<input type="checkbox"/> Combination
<input type="checkbox"/> Once daily feeding	<input type="checkbox"/> Twice daily feeding	<input type="checkbox"/> Free Feeding	

Detailed diet information

Brand Name _____

Main protein/carbohydrate _____

Wild game? Details _____

Cups fed (total per day) _____

Home cooked diet details _____

Treats/edible chews _____

Human grade food added _____

Other details about diet (e.g. known allergies, recent changes in diet) _____

Supplements (e.g. vitamins, acidophilus etc) _____

Does your animal eat grass/soil/rocks? _____

Physical Examination:

Shen	<input type="checkbox"/> Great	<input type="checkbox"/> Good	<input type="checkbox"/> OK	<input type="checkbox"/> Disturbance	<input type="checkbox"/> Loss				
Tongue Color	<input type="checkbox"/> Pale	<input type="checkbox"/> Red	<input type="checkbox"/> Yellow	<input type="checkbox"/> Deep red	<input type="checkbox"/> Purple				
Tongue Coat	<input type="checkbox"/> Pale	<input type="checkbox"/> Dark	<input type="checkbox"/> Yellow	<input type="checkbox"/> Thin	<input type="checkbox"/> Thick	<input type="checkbox"/> Greasy			
Tongue Moisture	<input type="checkbox"/> Dry	<input type="checkbox"/> Wet							
Tongue Size	<input type="checkbox"/> Small	<input type="checkbox"/> Large	<input type="checkbox"/> Swollen	<input type="checkbox"/> Shriveled					
Pulse	<input type="checkbox"/> Floating	<input type="checkbox"/> Deep	<input type="checkbox"/> Rapid	<input type="checkbox"/> Slow	<input type="checkbox"/> Full	<input type="checkbox"/> Thin	<input type="checkbox"/> Weak	<input type="checkbox"/> Slippery	
	<input type="checkbox"/> Choppy	<input type="checkbox"/> Soft	<input type="checkbox"/> Wiry						
Hair/Skin	<input type="checkbox"/> Wet	<input type="checkbox"/> Dry	<input type="checkbox"/> Alopecia	<input type="checkbox"/> Malodorous	<input type="checkbox"/> Dandruff	<input type="checkbox"/> Pruritis			
	<input type="checkbox"/> Hot	<input type="checkbox"/> Cold	<input type="checkbox"/> Poor Follicles						
Ears	<input type="checkbox"/> Hot	<input type="checkbox"/> Cold	<input type="checkbox"/> Red	<input type="checkbox"/> Scratching	<input type="checkbox"/> Alopecia	<input type="checkbox"/> Other			
	Discharge		<input type="checkbox"/> With odor	<input type="checkbox"/> With blood	<input type="checkbox"/> With Pus	<input type="checkbox"/> Other			
Eyes	<input type="checkbox"/> Red	<input type="checkbox"/> Pale	<input type="checkbox"/> Yellow	<input type="checkbox"/> Itchy	<input type="checkbox"/> Dry	<input type="checkbox"/> Swollen			
	Discharge		<input type="checkbox"/> Thick	<input type="checkbox"/> Watery	<input type="checkbox"/> Purulent	<input type="checkbox"/> Other			
Nose	<input type="checkbox"/> Wet	<input type="checkbox"/> Dry	<input type="checkbox"/> Crusting	<input type="checkbox"/> Depigmentation	<input type="checkbox"/> Hot	<input type="checkbox"/> Cold			
	Discharge		<input type="checkbox"/> Thick	<input type="checkbox"/> Clear	<input type="checkbox"/> Bloody	<input type="checkbox"/> With Pus	<input type="checkbox"/> Other		
Gums	<input type="checkbox"/> Pale	<input type="checkbox"/> Red	<input type="checkbox"/> Swollen	<input type="checkbox"/> Foul odor	<input type="checkbox"/> Bloody				
Lips	<input type="checkbox"/> Pale	<input type="checkbox"/> Red	<input type="checkbox"/> Purple	<input type="checkbox"/> Ulcers					
Oral Cavity	<input type="checkbox"/> Dry	<input type="checkbox"/> Wet	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Foul odor	<input type="checkbox"/> Hot	<input type="checkbox"/> Cold			
Lymph nodes	<input type="checkbox"/> Normal	<input type="checkbox"/> Swollen – details							
Growths/masses	<input type="checkbox"/> None	<input type="checkbox"/> Lipomas	<input type="checkbox"/> Other						
Seizure Activity	<input type="checkbox"/> None	<input type="checkbox"/> Rare	<input type="checkbox"/> Regular	<input type="checkbox"/> While sleeping	<input type="checkbox"/> Medicated				
Water Intake	<input type="checkbox"/> Normal	<input type="checkbox"/> Not drinking							
	<input type="checkbox"/> Increased thirst	<input type="checkbox"/> Decreased Thirst							
Food intake	<input type="checkbox"/> Normal	<input type="checkbox"/> Finicky	<input type="checkbox"/> Poor Appetite	<input type="checkbox"/> Ravenous					
Voice	<input type="checkbox"/> Loud bark	<input type="checkbox"/> Change of voice	<input type="checkbox"/> Weak						
Cough	<input type="checkbox"/> None	<input type="checkbox"/> Dry	<input type="checkbox"/> Wet	<input type="checkbox"/> Loud	<input type="checkbox"/> Worse at	night	<input type="checkbox"/> Weak	<input type="checkbox"/> Daytime	<input type="checkbox"/> With
	Exercise		<input type="checkbox"/> Nighttime						
Respiration	<input type="checkbox"/> Normal	<input type="checkbox"/> Heavy	<input type="checkbox"/> Strong	<input type="checkbox"/> Superficial	<input type="checkbox"/> Weak	<input type="checkbox"/> Rapid			
Feces	<input type="checkbox"/> Normal	<input type="checkbox"/> Loose	<input type="checkbox"/> Watery	<input type="checkbox"/> Dry	<input type="checkbox"/> Constipation	<input type="checkbox"/> Bloody			
	<input type="checkbox"/> Mucous	<input type="checkbox"/> Incontinent	<input type="checkbox"/> Strong odor	<input type="checkbox"/> Straining					
Urination	<input type="checkbox"/> Long stream	<input type="checkbox"/> Short stream	<input type="checkbox"/> Incontinent	<input type="checkbox"/> Malodorous	<input type="checkbox"/> Bloody				
	<input type="checkbox"/> Straining	<input type="checkbox"/> Marking							
Exercise	<input type="checkbox"/> Intolerance	<input type="checkbox"/> Reduced amount	<input type="checkbox"/> Over exercised						
	Details on daily activity level _____								
<hr/>									
Sleep	<input type="checkbox"/> Normal	<input type="checkbox"/> Too much	<input type="checkbox"/> Too little	<input type="checkbox"/> Vocalizes and waking up owner at night					
	<input type="checkbox"/> Soft Bed	<input type="checkbox"/> Hard Bed	<input type="checkbox"/> Muscle twitching when sleeps						
	<input type="checkbox"/> Indoors	<input type="checkbox"/> Outdoors	<input type="checkbox"/> Sleeping a lot in day						
Vomiting	<input type="checkbox"/> None	<input type="checkbox"/> Frequent	<input type="checkbox"/> Sporadic	<input type="checkbox"/> With undigested food	<input type="checkbox"/> With				
	digested food		<input type="checkbox"/> Hairballs	<input type="checkbox"/> With bile					
	<input type="checkbox"/> With blood	<input type="checkbox"/> Just after eating	<input type="checkbox"/> During the night						
	<input type="checkbox"/> Large amount	<input type="checkbox"/> Small amount							
Stiffness	<input type="checkbox"/> Acute onset	<input type="checkbox"/> Chronic							
	Worse	<input type="checkbox"/> in morning	<input type="checkbox"/> in evening	<input type="checkbox"/> with cold	<input type="checkbox"/> with heat				
		<input type="checkbox"/> With damp	<input type="checkbox"/> after walk	<input type="checkbox"/> before walk					
	Massage	<input type="checkbox"/> Enjoys	<input type="checkbox"/> Resists						