Oyster River Veterinary Hospital

Alternative Medicine Small Animal Questionnaire

Date:

Patient Name:

Major Complaints:

Current Medications:

Current Diet/Food:

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1. How is energy level?

2. How is appetite?

3. Any vomiting?

4. Thirsty?

5. Defecation (frequency, texture, blood or mucous, constipation, gas)?

6. Urination (frequency, color, odor, straining, leakage)?

7. Preference for cool or warm places to sleep?

8. Problems falling asleep / staying asleep? Dreaming?

9. Mood / behavior changes (anger, restlessness, fearfulness, etc.)?

10. Gait (lameness, stiffness, exercise intolerant)?