On Point Acupuncture and Veterinary Services
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Thank you for choosing On Point Acupuncture and Veterinary Services to treat your pet! Please take a few minutes to complete the following forms and email to info@onpointvetservices.com back at least 48 hours prior to your appointment. If you need to cancel or reschedule your appointment, please provide at least 24 hours notice to avoid a 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 Text 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 Titers:_____Other Pets in the house?:_____

DIET INFORMATION – Please check one:

Dry: [ ] No [ ] Yes

Canned: [ ] No [ ] Yes

Homemade: [ ] No [ ] Yes

Raw: [ ] No [ ] Yes

Eats Free Choice: [ ] No [ ] Yes

Set Meal Times: [ ] No [ ] Yes

Treats per day: _____

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:

_____

_____

_____

_____

_____