Today's Date _____________
Client ID # ______________

Integrative Veterinary Therapies Questionnaire

Dr. Albert Lynch, DVM CVCP CVA

Client's First and Last Name ____________________________

Contact Phone Number________________________________

Pet's Name________________________ **Age/DOB**__________

Sex______; **Species**___________; **Breed**______________

What is your primary concern for this visit? ____

____

____

What do you hope to achieve with Integrative Therapies? ______________________________

____

____

When did the symptoms begin? ____

<u>Current:</u>

Medications ____

____

Supplements ____

____

Diet ____

____

Exercise ____

____

- **When was your pet's last bloodwork?** 1 week; 1 mo; 3 mos; 6 mos or longer; Never
- **Do you have a regular Veterinarian?** … Yes …No
  - **If yes, would you like us to communicate with them following your pet's visits?**
    … No … No preference … Yes, Primary Veterinary Clinic Name:_______________