Patient Questionnaire

Balanced Paws
Veterinary Rehabilitation and Acupuncture

2704 W Michigan St
Duluth, MN 55806

218-481-7373
info@balancedpaws.vet

By Appointment Only: 9:00am-4:00pm (M, T, Th, Fr)

Patient Name:	
Client Name:	
Reason for Visit:	
Indicate any symptoms (change in activity, weakness, worsening of lameness, etc.) your pet is experiencing. How long has your pet experienced these symptoms?	
Describe how your pet has responded to any therapies at this time.	
What goals are you looking to accomplish with your pet in physical rehabilitation?	
Is your pet under cage rest restrictions? If so, for how long?	
Can your pet stand on their own?	
When did you last see your referring veterinarian?	
Does your pet have a history of seizures? If yes, please elaborate.	

	Yes	No
1.) Is the patient currently on medications/supplements? (Fill in table below if applicable)	☐	☐
2.) Has the patient had diagnostics performed, including lab work, radiographs, MRI/CT? (If yes, please send to info@balancedpaws.vet, if your referring veterinarian hasn't already done so.)	☐	☐
3.) Has the patient had any recent surgery? (Please describe type of surgery and date if applicable)	☐	☐
4.) Has the patient received any rehabilitation or acupuncture treatment before? (Please describe if applicable)	☐	☐

Current Medications and Supplements

1.)		4.)	
2.)		5.)	
3.)		6.)	

Does your pet have any allergies to medications? Please list if applicable.	

Eating Habits

Current diet (including amount being fed per day):	
What type of treats does your pet eat each day, and how many?	
Do you give your pet any table scraps? If so, what kinds and how much?	
Does your pet have any food allergies? Please list if applicable.	

Behavior	
How does your pet do with unfamiliar people?	
How does your pet do with other dogs or cats?	
Has your pet ever required a muzzle for an exam/procedure at the veterinarian before?	

Pain and Stiffness	
Does your pet have any sensitive areas on his/her body? Please describe.	
Do you think your pet is in pain currently? If so, where is he or she painful?	
Do you feel your pet is stiff in the morning?	
Does your pet's stiffness seem to resolve or worsen throughout the day? Please describe.	

Description of Gait	Yes	No
Does your pet appropriately use all four limbs when **walking**?	☐	☐
Does your pet appropriately use all four limbs when **trotting**?	☐	☐
Does your pet appropriately use all four limbs when **running**?	☐	☐
If no to any of the above, please explain:		

Activity and Home Environment	
What activities does your pet enjoy doing on a regular basis? How much time is spent doing these activities?	
If your pet has had surgery or a lifestyle change, what kind of activities does he/she like to do at home now?	
Description of walks and/or yard time each day:	Time outside and frequency: Distance if walking/running: Leashed or free-roam:
What type of home environment does your pet navigate in? What challenges might they encounter? (How many stairs, what type of flooring, etc.)	

Description of Function (Please indicate below if your pet has a problem doing any of the following activities.)	Yes	No
Jumping UP (for example, getting into the car or onto the bed)	☐	☐
Jumping DOWN (for example, getting out of the care or of the bed)	☐	☐
Climbing UP (for example, stairs, ramps, or curbs)	☐	☐
Climbing DOWN (for example, stairs, ramps, or curbs)	☐	☐