



On Point Acupuncture and Veterinary Services
Karen C Prine DVM, MS, CVA
Venice, Florida
Phone: 941.220.9414
Email: info@onpointvetservices.com

Thank you for choosing On Point Acupuncture and Veterinary Services to treat your horse! Please take a few minutes to complete the following forms and email (info@onpointvetservices.com) them 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: _____

Barn Name & Location (if different than Address listed above): Barn: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Alternate Phone: _____

Email: _____

Primary Veterinarian: _____ Name of Clinic: _____

Veterinarian Phone #: _____ Farrier: _____

How did you hear about us? _____

Are you okay with Appointment Email Reminders? Yes No Text Reminders Yes No

Has your horse previously had: chiropractic (Yes/ No); acupuncture (Yes/ No), massage (Yes/ No)

HORSE INFORMATION:

Horse: _____ Breed: _____

Age or Date of Birth: _____ Sex: _____ Color: _____

Horse's Origin (Breeder, Auction, Rescue, etc.): _____

Horse's Personality: _____

Horse's Job/Occupation: _____

Habbits/Vices: _____

Date of Last Teeth Float: _____ Dental Abnormalities: _____

Date of Last Deworming & Product Used: _____

Date of Last Vaccines or Titters: _____

DIET INFORMATION:

(include brand, amount, & frequency of feed and hay)

CURRENT MEDICATIONS:

Name of Medication:

Dosage and Frequency Given:

Name of Medication:	Dosage and Frequency Given:

CURRENT SUPPLEMENTS/HERBAL FORMULAS:

Name of Supplement:

Dosage and Frequency Given:

Name of Supplement:	Dosage and Frequency Given:

HORSE PREFERENCES – Please check all that apply:

Seeks the Sun:	<input type="checkbox"/>	Likes Massage:	<input type="checkbox"/>
Seeks the Shade:	<input type="checkbox"/>	Likes Grooming	<input type="checkbox"/>
Hard Surfaces:	<input type="checkbox"/>	Prefers Limited Touching:	<input type="checkbox"/>
Soft Surfaces:	<input type="checkbox"/>	Likes Company of People:	<input type="checkbox"/>
Prefers to Relax:	<input type="checkbox"/>	Likes Company of Other Horses/Animals	<input type="checkbox"/>
Prefers to Work:	<input type="checkbox"/>	Prefers Alone Time:	<input type="checkbox"/>
		Enjoys Children:	<input type="checkbox"/>

PHOBIAS – Please check all that apply:

Other Animals:	<input type="checkbox"/>
Certain Objects:	<input type="checkbox"/>
General Loud Noises:	<input type="checkbox"/>
People:	<input type="checkbox"/>
Other:	<input type="checkbox"/>

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:

(Include any history of injury, illness, colic, or emotional disturbances. Injuries include falls, lamenesses, wounds, head trauma, foot problems, fractures, and surgery.)

Date of Occurrence:

Description of Problem:

KNOWN ALLERGIES OR SENSITIVITIES:

Foods:	
Drugs:	
Environmental:	
Vaccines :	

TRAINING PROBLEMS:

(include stiffness, asymmetries, gaiting abnormalities, biting problems)

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:
