

## Acupuncture Herbal Medicine Whole Food Nutrition Holistic Animal Care

Kimberly Hoover, L.Ac., M.S.T.O.M., D.N.B.A.O. P.O. Box 1625, Penn Valley, CA 95946 (530) 575-5620 acucaresd@gmail.com

## **INTAKE FORM FOR CATS**

Your name:	e:Date:						
Address:							
City	State	Zip					
Home Phone: ()Em	ail:						
Work Phone: ()	Cell:						
What is your preferred method of contact:	Call	Text	Email				
May I leave voicemail/text messages/emails re	egarding app	oointments?	Yes	No			
Your cat's name is:							
Cat Breed:	Cat age:						
Please supply any relevant history (medical and/or behavioral) regarding your cat's problem:							
Please list any medications or supplements y	our cat is tak	king and why:					

Please take your time with the following questions. Your answers help to determine what your cat's 'type' is according to Oriental Medicine Principles. This information leads to the best overall result in treatment. Please mark the box that best fits your answer.					
1. My c	, ,	occur or worsen a		J	day: (please check)

- 3am-7am 7am-11am 11am -3pm 3pm-7pm
  7pm-11pm 11pm-3am
- 2. My cat's symptoms occur or worsen during which season:

Spring Summer Fall Winter

3. My cat's symptoms are worse with the following:

Wind Dampness Dryness N/A

## Mood/Behavior

1. My cat acts: Angry Restless Fearful of strangers/noises Depressed Worried Bullies other animals Anxious/Hyperactive Other 2. My cat's energy level is: Normal High Low 3. My cat's tolerance to heat is: Normal High Low 4. My cat's tolerance to cold is: Normal High Low

## **Digestion/Elimination**

- 1. My cat's appetite is: Normal High Low
- 2. My cat's thirst is: Normal High Low
- 3. My cat vomits: Rarely Sometimes Often How often\_\_\_\_\_
- 4. How many times a day does your cat have a bowel movement?

0-1 1-2 2-3 3+

5. The stool's texture is: Over dry Formed Loose Diarrhea

6.	Is there any abnormal col	or or odor?	Yes	No If s	o, what			
7.	Is there any noticeable st	raining?		Yes	No			
8.	How many times a day does your cat urinate?							
	0-1 1-2	2-3		3+				
9.	Is there any abnormal col	or or odor?	Yes	No If s	o, what			
10.	. Is there any noticeable p	ain?		Yes	No			
Die	Diet/Allergies							
1.	What kind of food is your cat eating?							
	Dry food What bra	ınd:						
	Wet food What brand:							
2.	2. Do you rotate your cat's food/protein source? Yes No							
3.	List any food allergies: N/A							
4.	Does your cat have any di	scharges?	Eyes	Nose	Ears	Other_		
5.	Does your cat experience	itching?		Low	Medi	um	High	
6.	Where is the itching?	Paws	Ears	Othe	r			