Wellness Roots
Chiropractic & Nutrition Center

Animal Intake Form

Animal Name:_____ Date:_____

Owner Name: _____

Address:_____

City:_____ State:_____ Zip:_____

Contact Phone: _____

Animal Date of Birth:_____ Animal Age (_____) Referred By:_____

Email:_____

☐ I would like to be put on the Wellness Roots Chiropractic & Nutrition Center email list to receive office updates and information, newsletters and promotions.

Has your animal ever received chiropractic care before? _____yes _____no

About Your Animal Health:

Yes	No		Explain:
__	__	Any hospitalizations?	_____
__	__	Any major traumas?	_____
__	__	What food does your animal eat?	_____

Primary Reason for Consulting Office:

Present complaint:_____

When did this first begin?_____

Has this condition happened before?_____

Is this condition worse in the: morning afternoon evening during sleep

Is this issue getting: worse better staying the same

Have you seen anyone for this issue?_____

Are you using any home remedies?_____

Other Symptoms:

___Seizures
___Back spasms
___Sleeping problems
___Difficulty getting Up
___Nervousness
___Tension
___Irritability
___Exhaustion
___Diarrhea
___Fever
___Shortness of breath
___Fatigue
___Depression
___Constipation
___Stomach Upset
___Other_____
___Loss of balance
___Fever
___Excessive chewing
___Excessive drinking
___Excessive licking

Final Details:

Has there been any:
Medical care for this problem in the past?_____
Prescription medication? Please list:_____
Over the counter supplements?_____
Surgery and/or organs removed?_____
Any other pertinent medical or health issues you would like us to know about your animal?
_____
_____
_____

Owner Signature:_____ Date:_____

Doctor Signature:_____ Date:_____