NAME OF OWNER (Last, First, M.I.):

ADDRESS OF OWNER:

Date:
SX or Injury Date:
Phone:
Email:
Alt. Phone:

HEALTH HISTORY QUESTIONNAIRE

Name of Animal ☐ M ☐ S ☐ G	**Birth Year or DOB:** (approx. age if unknown)
Breed/Discipline	
Attending veterinarian:	**Date of last physical exam:**

PERSONAL HEALTH HISTORY

Immunizations and dates:	☐ Tetanus	☐ West Nile
	☐ Rabies	☐ Other
	☐ Influenza	☐ Worming (type and date of last dose)

List any medical problems that have been diagnosed by a veterinarian

Surgeries

Year	Reason	Diagnosis or Treatment

Other Injuries or Conditions

Date	Symptoms or Cause	Diagnosis or Treatment

Please turn to next page

List medications, supplements, herbal remedies…		
Name the Drug or Supplement	Purpose	Dose and Frequency
Allergies to medications		
Name the Drug	Reaction Caused	

HEALTH HABITS

Exercise	☐ Sedentary (No exercise)			
	☐ Mild exercise (regular turn-out, occasional light riding)			
	☐ Occasional vigorous exercise (regular riding program 2-4x/week)			
	☐ Regular vigorous exercise (regular riding or training 4-6x/week)			
Describe Type of Activities (frequency of riding, type of training, challenges in work, recent activity)				
Describe Behavior (recent changes, temperament)				
Diet	Type of Forage:	Amount:	Frequency:	
	Type of Grain:	Amount:	Frequency:	
	Fat Supplement (ie: corn oil, flax seed…):			

FAMILY HEALTH HISTORY

	NAME	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Dam			**Siblings**	☐ M ☐ F	
Sire				☐ M ☐ F	

GENERAL HEALTH

Is the animal receiving physical therapy for a condition? (describe)	☐ Yes	☐ No
Is the animal eating and drinking normally? If not, describe.	☐ Yes	☐ No
Has the animal received massage before?	☐ Yes	☐ No
Does the animal adopt a specific posture regularly? (resting one foot, pointing a toe…)	☐ Yes	☐ No
Does the animal appear to sleep comfortably?	☐ Yes	☐ No
Is the animal restricted to stall rest?	☐ Yes	☐ No
Does the animal require bandaging? (describe)	☐ Yes	☐ No
Does the animal require hydrotherapy? (describe)	☐ Yes	☐ No
Is there any additional information you would like to share?	☐ Yes	☐ No

OTHER PROBLEMS

Check if you have noticed any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Performance
☐ Ears	☐ Genitals	☐ Other pain/discomfort:
☐ Throat or Lungs	☐ Circulation	

ADDITIONAL NOTES

NOTES REGARDING MASSAGE PROTOCOL DESIGN (INFLAMMATORY/REPAIRATIVE/REGENERATIVE STAGES)