ONDERA
VETERINARY SERVICES

Welcome!

Congratulations on your choice to focus time and energy on your pet's health through integrative care! I am passionate about supporting you and your pet through all stages of their life.

Integrative care is about whole health care for your pet. This means using all knowledge, whether traditional or holistic, to get the best outcome for your pet's health and wellbeing. Methods to achieve these goals may include nutritional changes, supplements, acupuncture treatments, herbal prescriptions, exercise/play time, and massage (Tui-na). I want your pet to lead a comfortable, happy life. We will help design a health and treatment plan that is specific to you and your pet's individual needs.

I (Dr. Jennifer Ondera) am trained in acupuncture and Traditional Chinese Veterinary Medicine (TCVM) by the Chi Institute in Florida. I incorporate this ancient, effective form of medicine to improve your pet's quality of life. The basis of TCVM is to discover imbalances within the body that may be causing disease or pain. This is the difference between traditional (western) and eastern medical techniques. While traditional medicine is excellent at treating symptoms in emergency situations like broken bones or acute infections, TCVM does a much better job of treating chronic problems and painful conditions. It also shines with the maintenance of health and wellness. This can be done early by recognizing your pet's individual pattern and tailoring the diet and environment to this pattern.

The initial appointment is meant to learn more about your pet's medical, behavioral, and nutritional history. We will discuss your goals for your pet's care and go over treatments and potential diagnostics. This process will help tailor a health plan specific to your pet.

In order to maximize our time together, please spend some time giving the Integrative assessment form careful thought. If you are unable to complete all of it, don't worry; we will be talking about this information when we are together.

You are a big part of your pet's health care. I welcome your thoughts and any questions/

Thank you,

Dr. Jennifer Ondera, DVM, CVA, CVFT

Integrative Assessment Form

Your Name:_____ Today's Date:_____
Your Pet's Name:_____ Age/Birthdate:_____
Gender:_____ Spayed/Neutered?_____ If yes, at what age?_____
Species and Breed:_____
Color/Markings:_____

History of Presenting Concern(s):

What prompted today's visit?_____

What are your goals for your pet's health?_____

When did you first notice symptoms?_____

Has your pet had x-rays or lab testing done within the past year?_____

If so, what clinic may I contact to request results/findings?_____

Other medical problems and/or procedures your pet has had in the past:_____

List your pet's regular diet including type/brand, quantity, frequency of meals:_____

Medication/Supplementation:

Please list your pet's current supplements:_____

Please list any other medications and preventatives:_____

Any intolerance (allergies) to foods or substances? If so, please describe:_____

ONDERA
VETERINARY SERVICES

Please help us understand your pet better:

When and where did you originally adopt your pet? Any difficult circumstances?_____

Describe your pet's personality in a few sentences. (Friendly, anxious, fearful, grouchy, etc…)_____

Does your pet have a temperature preference?_____

Does your pet prefer to lay on the floor, or in a cozy bed?_____

Does your pet dream often when sleeping?_____

How does your dog react to people visiting your home? Any difference if the people are strangers or friends?_____

How does your dog react to other dogs?_____

Symptoms:

Musculoskeletal:

Does your pet limp, or experience stiffness when moving?

☐ No ☐ Worse after lying down ☐ Worse after exercise ☐ Works itself out ☐ All the time

Please describe:_____

Does weather or temperature seem to affect your pet?

☐ No ☐ Cold ☐ Damp ☐ Wind ☐ Heat

Please describe:_____

Is there any area on the body that is painful to touch?_____

Please check any abnormalities:

Skin:

☐ Itching ☐ Dandruff ☐ Redness ☐ Masses ☐ Infection ☐ Odors ☐ Greasiness
☐ Hair Loss ☐ Thinning Fur ☐ Color Changes

Please describe:_____

_____

_____

Gastrointestinal/Urinary:

Oral Health:

☐ Dental Tartar ☐ Broken Teeth ☐ Tooth Discoloration ☐ Loose Teeth ☐ Bad Breath
☐ Breath Changes ☐ Red Gums ☐ Bleeding Gums ☐ Masses ☐ Tooth Loss

Please describe: _____

_____

Appetite:

☐ Voracious ☐ Normal ☐ Decreased ☐ Eats Slowly ☐ Drops Food
☐ Skips Meals ☐ Not interested ☐ Looks interested then walks away ☐ Picky
☐ Recent Change ☐ No Change

Please describe:_____

_____

Water Intake:

☐ Normal ☐ No Change ☐ Recent Change ☐ Too Much ☐ Not Enough

Please describe:_____

_____

Stomach:

☐ Abdominal Pain ☐ Gurgling/Noises ☐ Abdominal Fullness/Distension ☐ Burping
☐ Excessive Licking ☐ Vomiting Bile ☐ Vomiting Food ☐ Regurgitation (no abdominal heaving)

Please describe:_____

_____

Bowel Movements:

☐ Formed ☐ Soft ☐ Hard ☐ Diarrhea ☐ Undigested Food ☐ Mucous ☐ Blood
☐ Strong Odor ☐ Constipation ☐ Frequent ☐ Incontinence ☐ Gas

Please describe:_____

_____

Urination:

☐ Normal ☐ Accidents ☐ Incontinence ☐ Strong Odor ☐ Increased Amount
☐ Increased Frequency ☐ Small Amounts

Please describe:_____

_____

Heart and Lungs:

Breathing:

☐ Normal ☐ Pants a lot ☐ Labored ☐ Loud/Increased Noise ☐ Sneezing

Please describe:_____

_____

Coughing?

☐ No ☐ More at night ☐ With Exercise ☐ Seasonal ☐ Hacking ☐ Wheezing
☐ Moist ☐ Dry ☐ Weak ☐ Vomits after coughing ☐ Collapses

Please describe:_____

_____

Neurologic:

Behavior:

☐ No change ☐ Anxiety ☐ Pacing ☐ Howling ☐ New Fear ☐ Confusion

Please describe:_____

_____

Energy:

☐ No change ☐ Decreased ☐ Decreased Stamina ☐ Increased ☐ Sleeps a lot ☐ Weakness

Please describe:_____

_____

Seizures/Tremors? ☐ Yes ☐ No

Please describe:_____

_____

Incontinence?

☐ None ☐ Stool ☐ Urine, Small drops ☐ Urine, Large Puddles ☐ Licking

Please describe:_____

_____

Eyes/Ears/Nose:

Eye discharge or irritation:

☐ Clear ☐ Yellow ☐ Green ☐ White ☐ Watery ☐ Mucus ☐ Redness
☐ Dryness ☐ Masses ☐ Hair Loss

Please describe:_____

_____

Ear:

☐ Head Shaking ☐ Itchiness ☐ Odor ☐ Discharge ☐ Redness ☐ Pain
☐ Chronic infections

Please describe:_____

_____

Nose:

☐ Dry ☐ Wet ☐ Watery Discharge ☐ Mucus Discharge ☐ Bloody Discharge
☐ Crusting ☐ Congested

Please describe:_____

_____

Any other information we should know about your pet that you would like to describe?_____

_____

_____

_____

Your pet will continue to be seen by your primary care veterinarian for any routine care, illnesses, or injuries.

_____ _____

Signature Date