Date: _____
Referred By: _____

Large Animal Intake

Name: _____ Date of Birth: ____/____/_____

Species: _____Breed: _____

Color: _____

VETERINARIAN INFORMATION
Doctor: _____

Clinic Name: _____

Clinic Phone: _____ Clinic Email: _____

SUBJECTIVE INFORMATION

☐ New Patient/Initial Visit ☐ Follow up Visit ☐ Established New Condition

☐ Back Pain	☐ Dragging	☐ Issues with Lead
☐ Tail Pain	☐ Weak Bladder/Bowel	☐ Non-Weight Bearing
☐ Neck Pain	☐ Not Eating	☐ Abnormal Behavior
☐ Leg Pain	☐ Not Jumping	☐ Other
☐ Stiff	☐ Walks Sideways	
☐ Limping	☐ Difficult to Mount/Saddle	

What is the timeframe of the patient's injury? If known, please list below:
Date ____/____/_____

What triggered the injury:

☐ Unknown	☐ Shoe/Hoof Issue	☐ Jumping
☐ Hard Play	☐ Past Surgery	☐ Agility
☐ Kicked by Horse	☐ History of Trauma/Abuse	☐ Stepped in Hole
☐ Woke up with it	☐ Pasture	☐ Other

Please list any history of surgeries (leave blank if none or unknown)

_____

_____

Please list any history of medications or supplements (leave blank if none or unknown)

_____

_____

X-rays taken: ☐ If yes what area(s) and when _____

_____

Over

Activity level of horse: ☐ None/Inactive ☐ Moderate ☐ Highly Active

List any regular activities _____

_____

Has your horse previously had any of the following care:

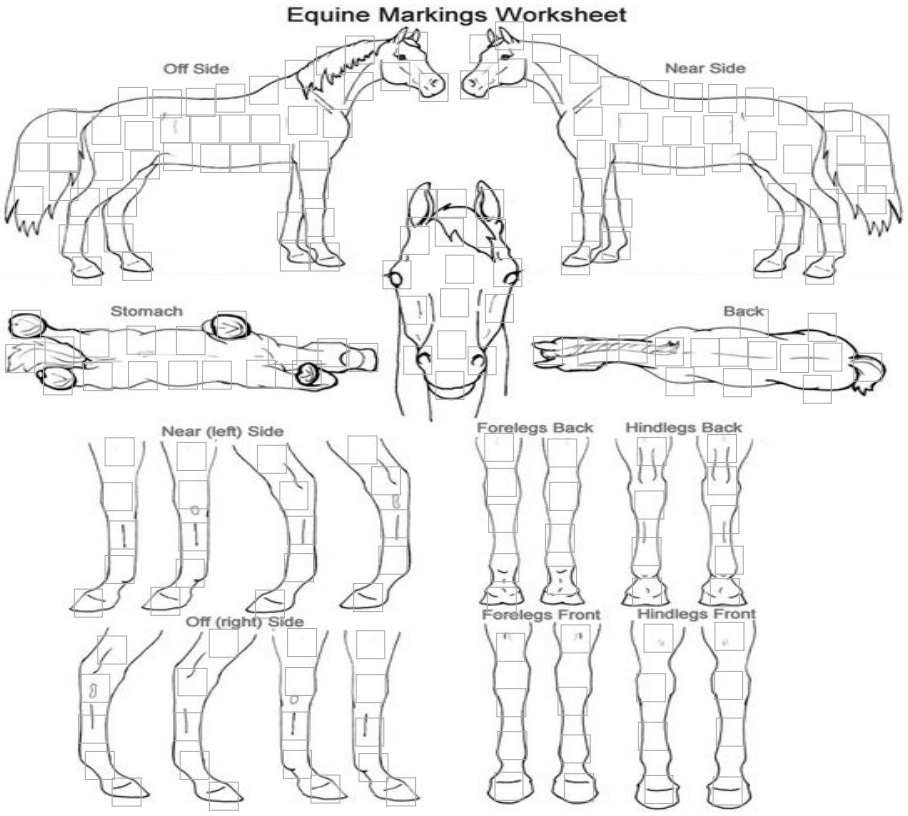
☐ Chiropractic ☐ Massage Therapy ☐ Physical Therapy ☐ Acupuncture

Anything else we should know? _____

_____

_____

Please mark where your horse's problem area is located on the diagram below.



☐ I certify that the above medical information is correct to the best of my knowledge.

☐ I authorize Livewell 7 to collect my horse's personal and medical information as documented above. In addition, I authorize the clinic to communicate with my veterinarian and/or referring doctor as deemed necessary for my horse's beneficial treatment.

☐ Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in the doctor's day that could have been filled by another patient. As such we require a 24 hour notice for any cancellations or changes to your appointment. Patients who provide less than a 24 hour notice, or miss their appointment, will be charged a cancellation fee.

_____ _____

Horse Owner Name Horse Owner's Signature

Date:____/____/_____