Juliea McCall, DVM
Equine Veterinary Care
Acupuncture & Chiropractic
(585) 662-7617

Horse's Name:_____

Age:_____ Breed:_____ M/S/G Date:_____

Stable Address:_____

Owner Name:_____

Address:_____

Phone(s):_____Email:_____

Primary Veterinarian: If Dr. McCall is not your primary care veterinarian, and she will be providing chiropractic and or acupuncture service only, please write your primary care veterinarian's name here_____
Do you give Dr. McCall permission to communicate with your primary veterinarian, if necessary, regarding her exam findings, diagnoses, and your horse's health?
(please circle one) Yes / No

Current Medications:_____
Any Supplements or Herbs:_____
Horse's Diet:_____

Patient Presenting Complaint –
Please describe the reason your horse is being seen today:

Is there anything that worsens the condition? (weather, work, medications, etc.)

Is there anything that improves the condition? (weather, work, medications, etc.)

Has your horse been seen previously for this same condition? Please describe.

What is your horse's job, and what are your goals for your Horse?

Is there anything else that you would like to tell us about your horse?