

NATURAL CARE INSTITUTE LLC
The Complete Tool Box of Holistic Veterinary Medicine
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THANK YOU FOR THE OPPORTUNITY TO CARE FOR YOUR PET(S).
PLEASE HELP US TO MEET YOUR NEEDS BY TAKING A MOMENT
TO COMPLETE ALL FORMS.

Mr. Mrs. Ms _____ Spouse/Other _____
Address _____ # _____ City _____ Zip _____
Home# _____ Work# _____ Ext: _____
Cell _____ E-Mail _____
Employers Name _____ Job Title _____
Employer Address _____ City _____ Zip _____
In case of emergency, call _____ at Ph# _____

- ❖ Were you referred to us? Yes No
 - ◆ If Yes, by whom? _____
 - ◆ If No, how did you hear about us? _____
- ❖ Previous diagnosis _____
- ❖ Did you bring or recently have done blood work, -rays, or records?
 - ◆ Yes No Brought _____
- ❖ May we contact your referring Veterinarian? Yes No
 - ◆ Dr. _____ At _____ Ph# _____
- ❖ Do you prefer?
 - Conventional/Western Medicine only?
 - Holistic therapies only?
 - Both

PAYMENT FOR ALL PROCEDURES, COUNSELING, PRESCRIPTIONS AND SURGERIES ARE DUE AT THE TIME SERVICES ARE RENDERED; YOU MAY PAY BY CASH OR CHECK WITH TWO PIECES OF ID, VISA OR MASTERCARD.

Birth date ____/____/____ Soc. Sec. # _____
NV Drivers License # _____ Exp. Date _____

Would you like to receive information about upcoming workshops? Yes No
Would you like to receive periodic E-mail newsletters? Yes No

THE INFORMATION THAT I PROVIDED ABOVE IS TRUE AND CORRECT. BY CHECKING THE ABOVE BOX, I HAVE AGREED TO RECEIVE E-MAIL FROM NATURAL CARE INSTITUTE INC.

Signature _____ Date _____

ANIMAL DESCRIPTION AND MEDICAL HISTORY

PLEASE FILL IN ALL KNOWN INFORMATION

Pet's name _____

Species (K9/Feline) _____

Breed _____

Color & Fur length _____

DOB or nearest estimate _____

Sex Male Female

Neutered/altered Neutered Spayed

Length of time owned _____

Supplements Yes No Type _____

Surgeries Yes No Type _____

Medications Yes No Type _____

Previous Treatments Yes No Type _____

(full details may be provided in the auto history)

Vaccine History	Date	Past Due	Refuse	Titer
DHLPP/C	_____	_____	_____	_____
Lymes	_____	_____	_____	_____
Bordatella	_____	_____	_____	_____
Rabies	_____	_____	_____	_____
FVRCPC	_____	_____	_____	_____
Fel. Leukemia	_____	_____	_____	_____
FIP	_____	_____	_____	_____
FIA (V)	_____	_____	_____	_____

Test History

Heartworm test Negative Positive

Fecal exam (worms) Negative Positive

Feline Leukemia Negative Positive

FIP/Corona (feline) Negative Positive

FIA (feline) Negative Positive

Pet's Origin Breeder Friend Individual Kennel Newspaper Pet Shop

Stray Humane Society Other

Comments: _____

AUTO HISTORY

DIRECTIONS: To aid the doctor in reaching an accurate diagnosis, a complete background on your pet is essential. Please fill out the following questionnaire. Answer each question to the best of your ability. If you do not understand a question or have doubts about your answer, leave the question blank or put a question mark (?). The doctor will go over the questionnaire with you upon your next visit.

REASON FOR VISIT: _____

MEDICAL DIAGNOSIS: _____

CHECK ALL YOU ARE INTERESTED IN: Doctor's recommendations

- Acupuncture Anal glands Applied kinesiology Blood work
 Detoxification Ear treatment Electromagnetic field energy
 Emotional balancing Enema Essential oils Eye treatment
 Medicated bath NAET/JMT Nail Trim Neuro-link balancing
 Nutritional consultation Spinal adjustment Teeth Cleaning Vaccinations
 X-rays Other _____
 Refills _____

DIET: Table leftovers Type _____
 Canned Commercial Food Type _____
 Dry Commercial Food Type _____
 Semi-dry Commercial Food Type _____
 Home Made Diet Type _____
Times per day fed: _____ Amount of food fed per feeding: _____

SUPPLEMENTS:

Yes No
What type? _____

Treats: Yes No
What type? _____

TYPE OF WATER:

Tap Filtered Bottled Distilled Constant access intermittent access

CHANGES NOTED:

Increase in water intake Decrease in water intake
 Increase in food intake Decrease in food intake
 Weight loss Weight gain
Appetite changes? Normal Ravishing Picky Absent

Urination:

I see my pet urinate? Yes No
Frequency of urination Increased Decreased Same
Volume of urine Increased Decreased Same
 Straining Change in color Change in odor Crying

DEFECATION:

I SEE MY PET DEFECATE? YES NO
HOW MANY BOWEL MOVEMENTS (BM'S) PER DAY? _____
FREQUENCY OF BM'S INCREASE DECREASE SAME
AMOUNT OR VOLUME INCREASE DECREASE SAME
 STRAINING BLOOD FLUID SOFT HARD MUCUS
OTHER CHANGES NOTED _____

DISCHARGES:

NOSE MOUTH VAGINA ANUS MAMMARY GLANDS EYES EARS
 OTHER _____

ABNORMAL BEHAVIORS:

OVERACTIVE UNDERACTIVE DEPRESSED LETHARGIC NOT MOBILE
 OTHER _____

OTHER SIGNS:

BEHAVIORAL COUGHING DENTAL EAR PROBLEM EMOTIONAL
 EYE PROBLEM LABORED BREATHING LIMPING LUMP/MASS PAIN
 SNEEZING VOMITING WHEEZING

DESCRIBE LOCATION, FREQUENCY, AND LENGTH OF TIME OCCURRING OF ABOVE SIGNS:

PLEASE DESCRIBE ANY OTHER SIGN OR SYMPTOMS THAT YOUR PET IS EXHIBITING:

ARE THE SIGNS:

INTERMITTENT CONSTANT QUICK TO SHOW GOTTEN WORSE GOTTEN
BETTER
 STAYED THE SAME DECREASING THE QUALITY OF LIFE

TREATMENTS GIVEN:

RESULT AFTER TREATMENT:

IMPROVED SOMEWHAT IMPROVED SLIGHTLY IMPROVED WORSENERD SAME
 OTHER _____

EXPECTATIONS:

DESCRIBE YOUR EXPECTATIONS OF HOLISTIC MEDICINE: CURATIVE PALLIATIVE
 PROLONG LIFE IMPROVE QUALITY OF LIFE WORTH THE TRY LAST RESORT
 TALKED INTO IT

Pet's Name _____

TREATMENT AND SURGICAL RELEASE FORM

I, the undersigned owner of admitted patient hereby authorize Dr. Brandt (and whomever she may designate as assistants) and/or her relief veterinarian to evaluate and administer such treatment as is necessary and such additional procedures as are considered therapeutic and/or diagnostically necessary, such as x-rays or blood tests and to perform any surgical procedures as are deemed necessary, on the basis of the findings during the course of the evaluation. I also consent to the administration of such anesthetics or tranquilizers as are necessary.

I also consent and authorize Dr. Brandt to diagnose, receive, prescribe for, treat with traditional or conventional medicine and/or complimentary medicine, applied kinesiology muscle test, homeopathic medicine or administer needle acupuncture, acuspark, essential oil therapies, herbal medicines, electromagnetic field therapy, N.A.E.T/JMT, injections, bio-energetic techniques, laser therapy, hydrogen peroxide therapy, chelation therapy, electromagnetic healing, chiropractic adjustment or surgery on my pet. I acknowledge that individual fees will be charged for various procedures. It is a client's responsibility to request an estimate prior to treatment. I understand that several of these procedures are new in the field and are still considered experimental and are not recognized by the FDA or the American Veterinary Medical Association (AVMA).

I acknowledge that Dr. Brandt currently employs alternative health care practices in her veterinary medical hospital. Homeopathy is not currently a recognized modality by the AVMA. The AVMA recommends that judgment be withheld regarding its suitability until more research has been conducted on animals. The recommendation of the AVMA is that the public should be informed in advance by the practitioner that homeopathy is currently considered an unconventional form of veterinary practice. Veterinary homeopathy techniques should be practiced only by a licensed veterinarian.

I understand that Natural Care Institute Inc. will use all reasonable precautions against injury, escape or destruction of my pet, but I will not hold Dr. Brandt liable or responsible in any manner whatsoever or the Natural Care Institute Inc. in any circumstances on account of treatment, care or safe keeping of my pet. I acknowledge that no guarantees or assurances have been or will be made to me as to the result of the examination or treatment at the Natural Care Institute Inc.

If an animal is not retrieved, a written notice will be mailed to the address below to remove the said animal(s). Five days after such written notice the animal(s) will be considered abandoned and may be found a new home as the Natural Care Institute Inc. deems best, and it is understood that its in so doing does not relieve me from paying all costs of its service and the use, of the hospital, including the cost of keeping the animal(s). I understand Natural Care Institute Inc. does not have the facilities to keep animals and therefore, payment for boarding will be billed by a third party.

I hereby certify that I have read and fully understand, and agree to the above and authorize medical and/or surgical treatment for my pet. I assume financial responsibility for all charges incurred to the patient, consent to release of medical information and authorize direct payment to the Natural Care Institute Inc.

**NO TREATMENT WILL BE DONE WITHOUT THE PREVIOUS
CONSENT OF THE OWNER.**

Signature of the Owner or Guardian _____

Owner's Address _____

Witness _____

**PAYMENT IS EXPECTED AT THE
TIME SERVICES ARE RENDERED.**

The Cost of Compassion

We do not provide care to collect fees; rather we collect fees to be able to provide care. These fees are a reflection of the cost of maintaining suitable facilities, equipment and support personnel to provide the level of care our clients expect. We endeavor to provide high quality care at a reasonable cost.

Recommendations for care are based solely on the specific needs of your pet's condition. We will make our clients aware of the products and services available for the benefit of their pet and guide them in their choices regarding the most important health option for their pet. However, the extent and therefore the cost of care given to any pet is ultimately determined by the pet's owner.

Payment for services is expected at the time of the visit.