

Whole Horse Herbal Evaluation & Consulation

(print and mail or fax)

Whole Horse Herbs - 559-683-4434 - 9-5 pacific time, FAX 559-642-2466 P.O. Box 544, Oakhurst, CA 93644

Owner name	Date
Phone	Fax
Shipping address	
Horse's name	Age
Type of work	
Health complaints (List and describe with length of time)	

Describe diet:

List drugs, medications and supplements with amounts:

List traumas (physical & emotional) surgeries, major illnesses with dates and out comes:

General emotional state

Stabling conditions: Example 10x10 stall with straw, 10 acre pasture with a pond or 12x12 corral

Below rate your horse current condition: Blank = not an issue, 1 = very mild or slight,

2 = moderate or occasional or 3 = severe or constant

<p>ST/SP</p> <p><input type="checkbox"/> colic - describe with dates</p> <hr/> <p><input type="checkbox"/> Stones</p> <p><input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> Loose or watery stools</p> <p><input type="checkbox"/> Hay belly/abdominal bloating</p> <p><input type="checkbox"/> Bloating appearance</p> <p><input type="checkbox"/> Stomach ulcers</p> <p><input type="checkbox"/> Low body weight</p> <p><input type="checkbox"/> Decreased appetite</p> <p><input type="checkbox"/> Bleeds easily</p> <p><input type="checkbox"/> Fatigued/lack luster</p> <p><input type="checkbox"/> Prolapses</p> <p><input type="checkbox"/> Worries</p> <p>LU/LI</p> <p><input type="checkbox"/> Easily catches colds</p> <p><input type="checkbox"/> Frequent respiratory infections</p> <p><input type="checkbox"/> Coughs</p> <p><input type="checkbox"/> Wheezes</p> <p><input type="checkbox"/> Heaves</p> <p><input type="checkbox"/> Shallow breathing</p> <p><input type="checkbox"/> Dry skin</p> <p>HT/SI</p> <p><input type="checkbox"/> Very thirsty</p> <p><input type="checkbox"/> Hoot feet</p> <p><input type="checkbox"/> Sore throat</p> <p><input type="checkbox"/> Dislike of hot weather</p> <p><input type="checkbox"/> Over heats easily</p> <p><input type="checkbox"/> Gum problems</p> <p><input type="checkbox"/> Tongue sores</p> <p><input type="checkbox"/> Skin eruptions/hives</p> <p><input type="checkbox"/> Cysts/ tumors</p>	<p>LV/GB</p> <p>Eyes:</p> <p><input type="checkbox"/> Dry eyes</p> <p><input type="checkbox"/> Red eyes</p> <p><input type="checkbox"/> Watery eyes</p> <p><input type="checkbox"/> Eye infections</p> <p><input type="checkbox"/> Poor eyesight</p> <p><input type="checkbox"/> Sensitive to light</p> <p><input type="checkbox"/> Sensitive to wind</p> <p>Skin:</p> <p><input type="checkbox"/> eczema - damp skin</p> <p><input type="checkbox"/> dry itchy skin</p> <p><input type="checkbox"/> Warts</p> <p>Personality:</p> <p><input type="checkbox"/> Nervousness</p> <p><input type="checkbox"/> Irritability</p> <p><input type="checkbox"/> Easy to anger</p> <p><input type="checkbox"/> Frustration</p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Jealously</p> <p><input type="checkbox"/> Flank tenderness/pain</p> <p><input type="checkbox"/> Chinchy</p> <p>Mares</p> <p><input type="checkbox"/> irregular cycles</p> <p><input type="checkbox"/> mood changes</p> <p>Hoof condition</p> <p><input type="checkbox"/> Dry</p> <p><input type="checkbox"/> Cracks</p> <p><input type="checkbox"/> Hard</p> <p><input type="checkbox"/> Soft</p> <p><input type="checkbox"/> Slow growing</p> <p><input type="checkbox"/> Dished</p> <p><input type="checkbox"/> Ridges</p>	<p><input type="checkbox"/> Founder/laminitis</p> <p>date: _____</p> <p>currently: _____</p> <p>KD/UB</p> <p>Hair: describe</p> <p>mane/tail _____</p> <p>body hair _____</p> <p>additonal hair comments _____</p> <p><input type="checkbox"/> Edema/stocking up:</p> <p>location: _____</p> <p>Lumbar Pain (Lower back)</p> <p><input type="checkbox"/> Hind end weakness</p> <p><input type="checkbox"/> Is it tender on palpation</p> <p><input type="checkbox"/> Sore/weak hocks</p> <p><input type="checkbox"/> premature aging</p> <p><input type="checkbox"/> dislike of cold</p> <p><input type="checkbox"/> frequent urination</p> <p><input type="checkbox"/> Color of urine</p> <p><input type="checkbox"/> kidney stones</p> <p><input type="checkbox"/> perspires very easily</p> <p><input type="checkbox"/> cold extremities</p> <p><input type="checkbox"/> rapid weight changes</p> <p><input type="checkbox"/> loose or lost teeth</p> <p><input type="checkbox"/> reduced sexual energy</p> <p><input type="checkbox"/> increased sexual energy</p> <p><input type="checkbox"/> infertility</p> <p><input type="checkbox"/> difficult pregnancies</p> <p><input type="checkbox"/> Hypothyroid</p> <p><input type="checkbox"/> poor concentration</p> <p><input type="checkbox"/> fatigue</p> <p><input type="checkbox"/> describe _____</p> <p><input type="checkbox"/> unusual thirst/drinks a lot</p>
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