Visceral Synergy

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Patient Profile

Please complete the following forms thoroughly to assist Dr. Mariotti in his diagnosis and treatment. This will become a part of your child's confidential medical record and will not be shared unless you expressly authorize its release. Please print clearly.

Today's Date: _____

Last Name: _____ **First Name:**_____ **MI:**_____

Date of Birth: _____ **Age:** _____ ___M, ___F

Address: _____

Home Phone: _____ **Work Phone:** _____

Emergency Contact: _____ **Phone:** _____ **Relation:** _____

How did you find out about Visceral Synergy? _____

What brings you and your child to my office today? _____

How do you hope your life will change for your chld as a result of working with me? _____

What are the most significant changes you have made to improve your child's health? _____

_____

What is your most basic feeling about your child's health condition e.g. fear, uncertainty, resignation, anger, hopelessness, or hope?_____

What would make life more joyful for your child? _____

May Dr. Mariotti contact you via email, with labs, treatment plans and education? Yes ___ No ___

If "yes" please print your email address clearly: _____ @ _____ . _____

Health Risks

Smokers in household: ___ Yes, ___ No

Method of birth control/protection (if applicable):

_____

Any known allergies to drugs, herbs, foods, etc.

_____

Current Health Concerns for Your Child

Describe top four health concerns, their duration in order of importance.

	Date of onset	Description
1.		
2.		
3.		
4.		

Describe what you think might be the causes of your child's issues (if known or suspected): _____

_____

Has your child had the same/similar problems before? Yes___ No____

What activities worsen the problem? _____

What activities improve the problem? _____

Are your child's problems getting progressively worse? Yes___ No___

What treatments have you tried in order to resolve these concerns? _____

Are your child's problems interfering with you're their daily routine? : Play ___ School ___ Sleep ___ All ___ Other

_____

If your child's condition involves pain, please characterize type:

Ache ___ Sharp ___ Radiating ___ Constant ___ Intermittent ___

Please rate the amount of pain you think your child is generally experiencing (circle one):

Minor 1 2 3 4 5 6 7 8 9 10 Severe

Previous Treatment for Health Problems

None ___

Name of doctor/hospital: _____

Address: _____

Date first seen: _____ Date last seen: _____

What tests were done, including x-rays? _____

Pertinent test results: _____

Condition or diagnosis: _____

How was the condition treated? _____

Results of treatment: Good ____ Fair ____ Poor ____

Please list below other doctors seen for this condition: None ____

	Name	Address	Date	Testing/treatment
1.				
2.				
3.				
4.				

Additional remarks about previous treatment: _____

_____

Current primary Care Physician: _____ Phone: _____

Clinic Name: _____ Last Visit: _____

Provider's Address: _____

Does your child suffer from any other health problems from which you are not seeking consultation with me?

Yes ____ No ____ If yes, please itemize below:

	Doctor	Phone #	Condition	Date of onset
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

Have your child ever been placed on chemotherapy? Yes __ No__ If yes, please specify which ones and when was the last treatment?

_____

Have your child ever received radiation therapy? Yes __ No__ If yes, when was the last treatment? _____

_____

Health Maintenance Update

Please indicate approximate dates and results of last:

	Date:	Results:
Full Physical Exam:	_____	_____
Dental Exam:	_____	_____
Cholesterol Profile:	_____	_____
Urine Sample:	_____	_____
Blood Work:	_____	_____
PAP/Pelvic Exam (F):	_____	_____
Bone Density (DEXA) Scan:	_____	_____
Serum Vitamin D	_____	_____
Eye exam:	_____	_____
Colonoscopy or flexible sigmoidoscopy:	_____	_____
Other:	_____	_____

Female Health History

Age at first period (if applicable): _____ Date of last period (if applicable): _____

# of pregnancies (if applicable): _____ # live births (if applicable): _____

Date of last Pap test (if applicable): _____ History of abnormal Pap tests? Yes ____ No ____

History of irregular periods (if applicable)? Yes ____ No _____ Menstrual cycle length (if applicable): _____days

Duration of menstrual period (if applicable): _____days

Do you experience significant menstrual cramping? Yes ____ No ____

Is heavy bleeding a problem? Yes ____ No ____

Does your child have a history of endometriosis? Yes ____ No ____

Do your child have a history of infertility? Yes ____ No ____

Do your child have excessive unwanted hair growth? Yes ____ No ___

Do your child have a tendency toward premenstrual syndrome? Yes ____ No ____ (please describe symptoms) ____

_____

Do you have a family history of breast cancer, ovarian cancer, or osteoporosis?

Yes (circle appropriate condition above) ____ No ____

Describe any current menstrual or menopausal symptoms or concerns: _____

_____

Describe any current breast problems: _____

Did you breast feed your child? Yes ____ No ____ If so, please describe length of time for each child _____

_____

Current Medications

Please itemize all medications your child is currently using or have used recently, or if you are nursing your child what are you currently taking? Please be sure to include all over the counter medications and hormones, as well.

Name of drug	Reason for Use	Does	How Long	Prescribing Doctor / self

Supplements

Please list all vitamins, minerals, herbs, and other natural products you, or if you are nursing your childmare you currently taking?

Name of natural product	Reason for Use	Does	How Long	Prescribing Doctor / self

Please list any medications, supplements, environmental allergies, or intolerances and the reactions your child has experienced to various things: _____

How would you describe your child's general health? _____

Surgeries and Hospitalizations

Type of Surgery/Study	Date	Reason	Results

Major Illnesses, Emotional or Physical Trauma, and Accidents (not already listed)

Has your child ever been in an auto accident? Yes ___ No ____ Date:

_____

Describe: _____

Have your child had any sports injuries? Yes ____ No ____ Date:

_____

Describe: _____

Please describe any other falls, accidents, or injuries and indicate dates: _____

_____

Has your child ever experienced emotional trauma? Yes ____ No ____ Date:

_____

Describe: _____

Early Health History

Did you (mother) have any known problems during her pregnancy with you (illness, stress, medication, smoking, alcohol, traumatic delivery)? Yes __ No __ (specify) _____

Did you breastfed ___ or bottle-fed ___? If breastfed, please indicate duration _____

Is the home-life during childhood and adolescence loving and supportive, or were there significant stresses? Yes ___ No ___ (specify) _____

Please check if your child has had any of the following childhood illnesses:

Frequent ear infections ___ Colic ___ Eczema ___ Recurrent colds ___ Bronchitis ___ Pneumonia ___Meningitis ___

___ Other (specify) _____.

Was your child on frequent or prolonged antibiotic therapy? Yes ___ No ___ (specify) _____

Did your child receive standard immunizations? Yes ___ No ___

Did your child experience any adverse reactions to immunizations? Yes ___ No ___ (specify) _____

Which of the following vaccinations are you aware that your child has received: Pneumonia ___, Hepatitis A ___, Hepatitis B ___, Other Yes ___ No ___ (specify _____.

Does your child receive a regular flu vaccination? Yes ___ No ___

Environmental Sensitivities and Allergies

Odors: Yes ___ No ___ (specify) _____

Smoke: Yes ___ No ___ (specify) _____

Soaps: Yes ___ No ___ (specify) _____

Fumes: Yes ___ No ___ (specify) _____

Perfume: Yes ___ No ___ (specify) _____

Do your child have environmental allergies and how would you rate your reaction:

Dust: Yes ___ No ___ ; mild ___, moderate ___, severe ___

Grasses: Yes ___ No ___ ; mild ___, moderate ___, severe ___

Pollen: Yes ___ No ___ ; mild ___, moderate ___, severe ___

Pet dander: Yes ___ No ___ ; mild ___, moderate ___, severe ___

Mold: Yes ___ No ___ ; mild ___, moderate ___, severe ___

Lifestyle Habits

Please check major stresses:

School ___ Feelings of isolation ___ Bullying ___ Divorce in family ___ Health problems ___ Family stress ___

Other ___ please describe: _____

_____

Please describe your (mom and dad) occupation: _____

Please describe the quality of major relationships in your (mom and dad) life: _____

_____

Please indicate job satisfaction (mom / dad) : Excellent ___ Good ___ Fair ___ Poor ___

Sleep (child): Time arise: _____ Time retire: _____ Naps: _____

Quality of sleep: Well-rested ____ Tired upon awaking _____ Awaken during night ____

Sleep in total darkness _____ Sleep with some light in room_____

Exercise

(Specify how many days/week & # of minutes)

Exercise	Days / week	Minutes / session	Exercise	Days / week	Minutes / session
Walk			Dance		
Run			Yoga		
Bike			Skating		
Aerobics class			Stretching		
Weight lifting			Other		

Hobbies / Activities for Pleasure *(Indicate how many times a week)*		
Activity	**Times / week**	**Times / month**

How Does your child relax or relieve stress? _____

_____

On a scale of 1-10 (10 being the worst you can imagine) how would you rate your child's stress?

Minor 1 2 3 4 5 6 7 8 9 10 Severe

Coffee (amount/day): _____

Black tea (amount/day): _____

Soda pop (amount/day): _____

Liquor: None ____ Type and amount _____/day _____/week

Number of years using tobacco: _____ **Date(s) quite:** _____

Recreational drug use: None ___ Type and frequency: _____

Former history of recreational drug use? No ___ Yes ___ Please specify _____

Digestive Function

Describe any food sensitivities / intolerances your child has: Dairy ☐, Wheat ☐, Gluten ☐, Corn ☐, Sugar ☐, Eggs ☐, Citrus ☐, Coffee ☐, Alcohol ☐, Fatty foods ☐, Salty foods ☐, Spicy foods ☐, Meat ☐, Other ☐ (specify)

_____

Describe any digestive problems: _____

_____

Bowel movement frequency: _____

Does your loose bowel control ? Yes ___ No ___ Frequency: _____

Does your child usually have to strain to have a bowel movement? Yes ___ No ___

Does your child ever have blood with bowel movements? Yes ___ No ____

Have you ever see blood on the toilet paper? Yes ___ No ___

Are your child's stools ever black or tarry? Yes ___ No ___

Last time your child received antibiotics: _____

Urinary Function

Frequency (times/day): _____ **Passed easily? Yes ___ No ___**

Blood or sediment present? Yes ___ No ___

Does your child experience loss of bladder control? Yes ___ No ___ Frequency: _____

Does your child experience difficulty starting and/or stopping urinary flow? Yes ___ No ___

Does your experience pain with urination? Yes ___ No ___ Frequency: _____

Does your wet the bed at night ? Yes ___ No ___ Frequency: _____

Does your wet themselves during the day ? Yes ___ No ___ Frequency: _____

Diet History

Typical breakfast: _____

Typical lunch: _____

Typical dinner: _____

Typical snacks: _____

Frequency of dining out: _____ Frequency of eating fast foods: _____

Quantity of water consumed/day: _____ Is your water filtered? Yes ___ No ___

Foods your child avoids: _____ Foods your child craves: _____

History of eating disorder? Yes ___ No _

Family Health History

Please review the conditions listed below. Indicate those that are current health problems of a family member by writing the letter C under his/her column. Use a letter P to indicate a past problem. Spaces that do not apply should be left blank.

Condition	Father Age ____	Mother Age ____	Spouse Age ____	Brother/s Ages _____	Sisters/s Ages _____	Children Ages _____
Age at death:						
Alcoholism/ Addiction						
Alzheimer's Disease						
Allergies/ hay fever						
Asthma						
Anemia						
Arthritis (indicate type)						
Autoimmune (indicate type)						
Bleeding tendency						
Cancer ( )						
Cancer ( )						
Cancer ( )						
Cancer ( )						
Diabetes						
Depression						
Digestive problems						
Epilepsy						
Heart disease						
High blood pressure						
High cholesterol						
Kidney problems						
Liver disease						
Mental illness						
Migraine						
Obesity						
Osteoporosis						
Peptic ulcers						
Stroke						
Thyroid (low or high)						
Other (indicate)						
Other (indicate)						

Ayurvedic Constitution

On the following page you will find a relatively short summary self-test of your child's Ayurvedic constitution and is not meant to be exhaustive. Understanding your child's Ayurvedic constitution will help Dr. Mariotti in formulating future treatment plans as well increasing your self-awareness.

Instructions completing this test:

- **For each category, put a check in the box that most represents your child. Your child may have characteristics of all three choices. Make a choice, and decide on the box that is the closest to the way your child has been the most consistently throughout their life, especially their earlier years.**

- **Remember back to your child's earliest childhood years, and compare them to other children at that age. For example, was your child in the chubbiest 1/3, the skinniest 1/3, or the middle 1/3, of, say, 3 year olds?**
- **Make only 1 check for each category. Do not split answers. Put a check in each category.**
- **Do not overrate yourself as pitta. Since pitta is in the middle column, many people check the pitta column as a compromise.**
- **The total of all three columns should equal 20.**

Characteristic	Kapha	√	Pitta	√	Vata	√
Frame	Large frame Stout, Thick, Muscles not visible		Medium frame Moderately developed, Muscles visible		Thin, Poorly developed, Tall or short	
Body weight	Heavy, obese		Moderate		Low Prominent bones	
Disease Tendency	Mucus, congestion, water		Inflammation, Infection, Heat, Fever		Pain Nerve diseases	
Skin	Thick, oily, cool		Moist, Soft, Oily, Warm, Moles, Freckles, Acne, Pink		Dry, Rough, Cool, Thin, Cracked, Veins visible	
Complexion	Pale, white		Fair, Red (ruddy, flushed), Yellow		Brown, Black, Dull	
Hair	Thick, Oily, Wavy, Dark or Light		Soft, Oily, Fine, Yellow, red, Early gray, Balding		Brown, Black, Dry, Kinky, Wavy, Scanty, Coarse	
Joints	Thick, move smoothly		Medium, Soft, Loose		Thin, Crackling, Unstable	
Teeth	Large, White, Full		Moderate size, Soft, Pink, Bleeding gums		Protruded, Cracked, Spaces, Thin and receding gums	
Eyes	Big, Wide, Prominent, Blue, Thick, Oily, White sclera		Medium size, Penetrating gaze, Green, gray, Red or yellow sclera		Active, Dry, brown, Black, Small, Thin, Unsteady	
Elimination	Oily, Thick, Slow, Heavy		Loose, soft, oily		Constipation, hard, dry, Pain	
Activity	Lethargic, Stately		Moderate, Mid-length, Purposeful, Goal setting		Active, Talkative, Nervous, Short bursts	
Appetite	Slow, Steady		Excessive, Strong		Variable, Erratic, Low	
Thirst	Slight		Excessive		Variable	
Sleep	Heavy, Deep, Long, Excessive, Difficulty waking		Short and sound		Insomnia, Light	
Mind	Calm, Slow, Steady		Aggressive, Perceptive		Restless, Curious, Short attention	
Personality Strength	Loyalty, Calm, Contentment		Leadership		Creativity	
Personality Weakness	Greed, Attachment, Self-centered		Jealousy, Irritability, Aggression		Anxiety, Insecurity, Fear	
Memory	Slow to Memorize, Good retention		Moderate, clear		Generally poor Short term good, Long term poor	
Dreams	Water, Romance, Few Dreams		Angry, Passion, Color, Fire, Conflict		Active, Flying, Fear, Involved, Nightmares	
Speech	Slow, Melodious, Definite, Reticent		Cutting, Incisive, Argumentative, Convincing		Chaotic, Continuous, Quick, Talkative	
	Total		Total		Total	

Review of Systems

Please Indicate with a "C" if your child currently has or a "P" if your child previously had any of the following. Indicate type where appropriate.

	Constitutional		Mental		Neurological		Integumentary
	Severe Fatigue		Anxiety		Dizziness		Skin rash / itching
	Fever		Depression		Fainting		Skin infections
	Night sweats		Other mental issues		Recurrent headaches		Brittle nails
	Poor sleep				Migraines		Recent hair loss
	Apathy				Numbness		
					Weakness		
					Tingling		

	Endocrine		Immune System		Eye and Ear		Respiratory
	Thyroid disorder		Cancer		Loss of hearing		Freq. Sore throats
	Diabetes		Autoimmune		Ringing in ears		Freq. sinus infections
	Other:		Allergies		Recent loss of vision		Asthma
			Hay fever		Eye pain		Difficulty breathing
			Lymph nodes enlarged		Dry eyes		Shortness of breath
			Recurrent colds & flu		Recurrent sinusitis		Chronic bronchitis
							Chronic cough
							Tuberculosis
							Pneumonia (bacterial)
							Pneumonia (viral)
							Chest pain

	Gastrointestinal		Cardiology / Hematology		Genitourinary		Gynecological
	Stomach ulcers		Chest pain		Kidney failure		Menstrual cramps
	Acid reflux		Heart disease		Kidney infection		PMS
	Gas and bloating		Heart failure		Kidney stones		Menopause
	Constipation		Stroke		Bladder infection		Heavy menstrual flow
	Diarrhea (infectious)		Irregular heart beat		STD – Chlamydia		Hot flashes
	Diarrhea (bloody0		Hemorrhoids (external)		STD – HIV		Irregular cycles
	Blood in stools		Hemorrhoids (internal)		STD – HPV		Densities of breast
	Persistent nausea		Frequent nose bleeds		STD – syphilis		Other breast issues
	Recurrent vomiting		Varicose veins		STD – other		Breast discharge
	Liver disease		Poor circulation		Prostate enlargement		Vaginal discharge
	Hepatitis		Anemia		Sexual problems		
	Abdominal pain		Blood diseases		Loss of libido		
			Easy bruising				

	Musculoskeletal		Metabolic	Other (write in)
	Arthritis		Loss of appetite	
	Neck pain		Weight gain	
	Upper back pain		Weight loss	
	Mid-back pain		Weight redistribution	
	Low back pain			
	Leg pain			
	Arm pain			
	Stiffness_____			
	Bursitis _____			
	Hot / swollen joints			
	Ankle swelling			
	Fibromyalgia			