Dr. Jeanette Altieri
Dr. Louis Cavallo

Specializing In:
Pediatrics
Pregnancy
Family Care
Sports Performance

Dedicated to creating a healthier world naturally…

Date: ____________

Pediatric Patient Information *(Age 6-12)*

Name: ______________________________________ **Male** _____ **Female**_____

Parent's Name: ____

Address: __________________________ **City:** _________________ **Zip Code:** _________

Home Phone: __________________ **Mother's Work/Cell Phone:** _____________________

Father's Work/ Cell Phone: _________________________

Birth Date:_____________________ **Age:**_______________ **Weight:** ____________

Number of Siblings: _______

Birth History

Birth Weight _________ **Breast Fed:** ___**No** ___**Yes** **If Yes, How long?** _________

Type of Birth: Normal Vaginal _____ **Forceps** _______ **Breech**_________

Cesarean _______ **Home** ________ **Birthing Center** ________ **Hospital** ________

Delivery History/Problems: ____

School Info

Current School: ___________________________ **Current grade:**________

Use a backpack? ___**No** ___**Yes** **If Yes, approx. backpack weight?** ____________

Any Learning Difficulties? ____

Play sports? ___**No** ___**Yes** **Please List:** ______________________________________

Do you use a computer? ___**No** ___**Yes** **How many hours/wk?** _________

Play video games? ___**No** ___**Yes** **How many hours/wk?** __________

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Office (770) 513-8922 • Fax (770) 513-0547 • Insurance Dept. (770) 513-6565
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Medical History

Date of Last Visit to MD: ________________ Purpose: __________________________

Immunization History: ____

Has your child been treated on an emergency basis? ___________________________
If yes, please describe: ____

Possible Signs of Vertebral Subluxations Complex

(*Please circle ALL that apply*)

DIZZINESS BACKACHES HEART TROUBLE CHRONIC EARACHES

DIABETES COLDS/FLU ANEMIA POOR APPETITE BED WETTING

NECK PROBLEMS DISLEXIA JOINT PROBLEMS HEADACHES

DIGESTIVE DISORERS FAINTING HYPERACTIVITY CONVULSIONS

WALKING PROBLEMS ARM PROBLEMS ASTHMA SINUS TROUBLE

PARALYSIS EYE DISORDERS BROKEN BONES LEG PROBLEMS

ALLERGIES CONSTIPATION SLEEPING PROBLEMS COLIC DIARRHEA

BEHAVIORAL PROBLEMS "GROWING PAINS" LEARNING DIFFICULTY

SCOLIOSIS ADD/ADHD CAR ACCIDENT

Present History: ____

Surgery: ____

Medications: ____

Accidents: ____

Family History: ____

Insurance Information (*must be completed*)

Name of insured ______________________ Insured's employer ________________________

Birth date of insured _______Deductible amount ______ Has deductible been met? __Yes___No

Authorization for Care of Minor

I hereby authorize this clinic and its doctors to administer care as they so deem necessary to my son/daughter/ward. I realize that I am responsible for all fees charged by this clinic and that I will pay for **all services as they are performed. X-rays will remain the property of this clinic.**

Signed: ____________________________________ Date: ______________________________