

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 *(Birth - Age 5)*

Child's 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 _____

Type of Birth: Normal Vaginal ___ Forceps ___ Breech _____

Cesarean ___ Home ___ Birthing Center ___ Hospital _____

Delivery History/Problems: _____

Pregnancy History/Problems: _____

Was there Presence at Birth of: _____ Jaundice (yellow)

_____ Cyanosis (blue)

Feeding History

Breast Fed: ___ No ___ Yes If Yes, How long? _____

Formula Fed: ___ No ___ Yes If Yes, How long? _____ Type: _____

Introduced to Solids at: _____ Months, Cow's Milk at: _____ Months

Food/Juice Allergies or Intolerances: ___ No ___ Yes If Yes, Please List: _____

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Medical History

Date of Last Visit to MD: _____ Purpose: _____

Immunization History: _____

Has your child been treated on an emergency basis? ___No ___Yes
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 | FAINING | 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? ___No ___Yes

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 charges 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: _____