Dr. Jeanette Altieri
Dr. Louis Cavallo

Specializing In:
Pediatrics
Pregnancy
Family Care
Sports Performance

Date: _____

CONFIDENTIALPEDIATRIC *(Birth - 12)* HEALTH INFORMATION

Child's Full 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)

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

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

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

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

_____

_____

Current School: _____ Current grade: _____

Any Learning Difficulties? _____

Play Sports? □ Yes □ No If Yes, Please List: _____

Do you use a computer/play video games? □ Yes □ No If Yes, How many hours/wk? _____

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Medical History

Date of Last Visit to MD: _____ Purpose: _____

Immunization History: _____

Has your child ever been treated for an Emergency? □ **Yes** □ **No** If Yes, please describe:

_____

Possible Signs of Vertebral Subluxation Complex
(*Check ALL that apply)*

□ DIZZINESS □ BACKACHES □ HEART TROUBLE □ DIABETES □ ANEMIA □ CHRONIC EARACHES/INFECTIONS
□ FREQUENT COLDS/FLU □ POOR APPETITE □ BED WETTING □ NECK PROBLEMS □ DISLEXIA □ SCOLIOSIS
□ JOINT PROBLEMS □ HEADACHES □ DIGESTIVE DISORDERS □ FAINTING □ HYPERACTIVITY □ CONVULSIONS
□ WALKING PROBLEMS □ ARM PROBLEMS □ ASTHMA □ SINUS TROUBLE □ PARALYSIS □ EYE DISORDERS
□ BROKEN BONES □ LEG PROBLEMS □ ALLERGIES □ CONSTIPATION □ SLEEPING PROBLEMS □ COLIC
□ DIARRHEA □ BEHAVIORAL ISSUES □ CAR ACCIDENT □ GROWING PAINS □LEARNING DIFFICULTY □ ADD/ADHD

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 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.

Print Child's Full Name: _____

Signed: _____ Date: _____