NEWBORN HISTORY
Birth to 2 months

Today's Date ____________

Patient's Name ___________________________ Sex: M F Date of Birth ___________ Age ______

How did you hear about our office or website? (Please list where you've seen/heard about our office or what web search you used.) ______________________________________

<u>The following questions are designed to help the doctor provide the best possible spinal care for your child.</u>

How many hours does your baby sleep between feeds? During day _______ At night _______

Yes No
❑ ❑ Does your baby go to sleep easily? ____________________

Yes No
❑ ❑ Does baby have a preferred sleeping position? ____________________

Yes No
❑ ❑ Does baby cry if you change this sleeping position? ____________________

Yes No
❑ ❑ Does baby have any feeding difficulties? ____________________

Yes No
❑ ❑ Is baby being breast fed? If no, for how long was baby being breast fed ________ weeks/months

Yes No
❑ ❑ Does baby have a one sided breast-feeding preference? Preferred breast: Left / Right

Yes No
❑ ❑ Is baby formula fed? Which formula or other milk source? ____________________

Yes No
❑ ❑ Does baby frequently spit-up after feeding? ____________________

Yes No
❑ ❑ Does baby cry a lot? For How many hours each day? ____________________

Yes No
❑ ❑ Does baby pass a lot of intestinal gas? ____________________

Yes No
❑ ❑ Does baby have a preferred head position? ____________________

Yes No
❑ ❑ Does baby frequently arch his/her head and neck backwards? ____________________

Yes No
❑ ❑ Does baby cry or become irritable during a diaper change? ____________________

Yes No
❑ ❑ Has baby ever had a fever? ____________________

Yes No
❑ ❑ Has baby had any falls? ____________________

Yes No
❑ ❑ Has baby been in a car accident or near-miss? ____________________

Yes No
❑ ❑ Has baby had any other trauma? ____________________

Yes No
❑ ❑ Has your baby been vaccinated? ____________________

Yes No
❑ ❑ Do you have any other concerns you wish to discuss? ____________________