

## 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.) \_\_\_\_\_

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

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? \_\_\_\_\_