NEWBORN HISTORY

Birth to 2 months

Today's Date _____

Patient's Name _____ Sex: M F Date of Birth _____ Age _____

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 breast fed _____ weeks/mths

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 your 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? _____

_____