

**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? \_\_\_\_\_