NEWBORN HISTORY
(Birth to 2 Months of Age)

Date: ________________

Name of Child: ______________________________ Sex: M F Date of Birth: ____ /____ /_____ Age: ____

The reason for today's visit: ____
How many hours does your baby sleep between feeding? During the Day: _________ At Night: ___________

Yes	No	
☐	☐	Has your child ever had this problem before? ____
☐	☐	Has your child previously been treated for this problem? By whom?________________________
☐	☐	Has your child previously had chiropractic care? If yes, where? ____________________________ If yes, by whom? _______________________
☐	☐	Does your baby go to sleep easily? ____
☐	☐	Does your baby have a preferred sleeping position? ______________________________________
☐	☐	Does your baby cry if you change his/her sleeping position? _______________________________
☐	☐	Does your baby have any feeding difficulties? ____
☐	☐	Is your baby breast-feeding? If no, for how long was baby breastfed?_______________________
☐	☐	Does your baby have a one-sided breast–feeding preference? Right Left
☐	☐	Is your baby fed formula? Which formula or other milk source? _________________________
☐	☐	Does your baby frequently spit-up after feeding? ____
☐	☐	Does your baby cry a lot? For how many hours each day? ___________________________________
☐	☐	Does your baby pass a lot of intestinal gas? ____
☐	☐	Does your baby have a preferred head position? ____
☐	☐	Does your baby frequently arch his/her head and neck backwards? _________________________
☐	☐	Does your baby cry or become irritable during a diaper change? __________________________
☐	☐	Has your baby ever had a fever? ____
☐	☐	Has your baby had any falls? ____
☐	☐	Has your baby been in a car accident or near miss? _______________________________________
☐	☐	Has your baby had any other trauma? ____
☐	☐	Has your baby been vaccinated? ____
☐	☐	Any other concerns you wish to discuss? ____ ____