# Newborn History

**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 _____ During night _____

| | YES | NO | |
|---|---|---|---|
| Does your baby go to sleep easily? | ☐ | ☐ | _____ |
| Does baby have a preferred sleeping position | ☐ | ☐ | _____ |
| Does baby cry if you change this sleeping position | ☐ | ☐ | _____ |
| Does baby have any feeding difficulties? | ☐ | ☐ | _____ |
| Is baby being breast fed? | ☐ | ☐ | If no, for how long was baby breast fed? _____ weeks/months |
| Does baby have a side preference for feeding | ☐ | ☐ | Preferred breast: Left / Right |
| Is baby formula fed? | ☐ | ☐ | Which formula or other milk source? _____ |
| Does baby frequently spit up after feeding? | ☐ | ☐ | _____ |
| Does your baby cry a lot? | ☐ | ☐ | For how many hours each day? _____ |
| Does baby pass a lot of intestinal gas? | ☐ | ☐ | _____ |
| Does baby have a preferred head position? | ☐ | ☐ | _____ |
| Does baby frequently arch head/neck backwards? | ☐ | ☐ | _____ |
| Does baby cry/ become irritable during diaper change? | ☐ | ☐ | _____ |
| Has baby ever had a fever? | ☐ | ☐ | _____ |
| Has baby had any falls? | ☐ | ☐ | _____ |
| Has baby been in a car accident or near-miss? | ☐ | ☐ | _____ |
| Has baby has any other trauma? | ☐ | ☐ | _____ |
| Has baby been vaccinated? | ☐ | ☐ | _____ |
| Has baby ever had any negative reaction to vaccine? | ☐ | ☐ | _____ |
| Do you have any other concerns you wish to address | ☐ | ☐ | |

_____

_____

I certify that that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Parent's Signature: _____ Date: _____

Reviewed by Doctor: _____ Date: _____