

Birth and Newborn History
Birth to 2 months

Child's Name _____ Today's Date _____

Has your child had previous chiropractic care? Yes No When? _____

Did mom receive regular chiropractic care throughout her pregnancy? Yes No

The following questions are designed to help the doctor provide a detailed examination of your child.

Birth History:

Labor and Delivery

How long was the labor from the regular contraction to the birth? _____ hrs

How long the 2nd stage (the pushing phase) of the labor? _____ hrs

If C-Section:

Planned _____

Emergency _____

Yes No

Home birth Yes No _____

Vaginal Delivery Yes No _____

Was Anesthesia administered Yes No _____

Fetal distress Yes No _____

Meconium staining Yes No _____

Head presentation Yes No _____

Face presentation Yes No _____

Breech presentation Yes No _____

Baby's condition immediately after birth:

Baby's Crying: Baby cried immediately after birth: Y N

Cried strongly Weak cry Did Not Cry for _____ minutes

Baby's Color: Pink all over Blue face Blue hands/feet

Baby's activity: Arms and legs actively moving Floppy baby

Intensive Care: Was required: Y N Days in Neonatal Intensive Care Unit _____

Medication given at birth? _____ Vaccines administered _____

Birth weight _____ lbs/kgs Birth length _____ ins/cms Baby home on day _____

Child's Name _____ Today's Date _____

Newborn History

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

How many hours does your baby sleep between feedings? During day _____ At night _____

Yes No

- Does your baby go to sleep easily? _____
- Does your baby have a preferred sleeping position? _____
- Does your baby cry if you change this sleeping position? _____
- Does your baby have any feeding difficulties? _____
- Is your baby being breast fed? If no, for how long was baby breast feed _____ weeks/mths
- Does your baby have a one sided breast-feeding preference? Preferred breast: Left or Right
- 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? _____
- Do you have any other concerns you wish to discuss? _____

The statements made on this form are accurate to the best of my recollection and I grant permission for this office to examine my child and evaluate their health.

Parent/Guardian Signature

Date