LOMBARDI CHIROPRACTIC FAMILY HEALTH CENTER

NEWBORN HISTORY
BIRTH TO 2 MONTHS

Patient's Name: ____________________________ Parent's Name: ___________________

Address: __________________________________ Home Phone: _____________________

City, State, Zip: ____________________________ Cell Phone: ______________________

Sex: M F D.O.B. ________________ Age: _____ SS#: ____________________

Reason for Today's visit? ____

When did this problem occur? ____

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

YES☐ NO☐ Does your baby go to sleep easily? ____________________________________

YES☐ NO☐ Does your baby have a preferred sleeping position? ______________________

YES☐ NO☐ Does your baby cry if you change the sleeping position? __________________

YES☐ NO☐ Does your baby have any feeding difficulties or frequent spit ups after? _______

YES☐ NO☐ Is your baby breast-fed? If no, how long was your baby breast fed for? ________

YES☐ NO☐ Does your baby cry a lot? For how many hours each day? _____________

YES☐ NO☐ Does your baby pass a lot of intestinal gas? _____________________________

YES☐ NO☐ Does your baby frequently arch his/her head and neck backwards? ___________

YES☐ NO☐ Does your baby cry or become irritable during diaper changing? _____________

YES☐ NO☐ Has your baby ever had a fever? ______________________________________

YES☐ NO☐ Has your baby been in a car accident or near miss? ________________________

YES☐ NO☐ Has your baby ever has any falls or other traumas? ________________________

YES☐ NO☐ Has your baby been vaccinated? ______________________________________

YES☐ NO☐ Do you have any other concerns you wish to discuss? ______________________

Parent or Guardian Signature: _________________________________ Date: ____________