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? _____

_____

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History of Pregnancy

Date: _____
Name of child: _____ Sex: M F Date of Birth: ___/___/___
Mother's name: _____ How many other children do you have? ____
How long did it take you to conceive (with this pregnancy)? _____months/years
What was the term of your pregnancy (at delivery)? _____weeks (40 weeks is considered full term)
What was your estimated due date? _____

DURING YOUR PREGNANCY, DID YOU HAVE ANY OF THE FOLLOWING:

	Yes	No	Describe
Falls?	☐	☐	_____
Motor Vehicle Accidents?	☐	☐	_____
Near-miss MVA?	☐	☐	_____
High Blood Pressure?	☐	☐	_____
Diabetes?	☐	☐	_____
Anemia?	☐	☐	_____
Morning Sickness?	☐	☐	_____
Indigestion/Heart burn?	☐	☐	_____
Stress?	☐	☐	_____
Seizures?	☐	☐	_____
Swollen Ankles?	☐	☐	_____
Thyroid Problems?	☐	☐	_____
Heart Problems?	☐	☐	_____
Headaches?	☐	☐	_____
Back Pain?	☐	☐	_____
Abnormal Bleeding?	☐	☐	_____
Were You Hospitalized?	☐	☐	_____
Ultrasounds? If yes, how many?	☐	☐	_____
Any Other Illnesses?	☐	☐	_____

DURING YOUR PREGNANCY, DID YOU USE ANY OF THE FOLLOWING:

	Yes	No	Describe
Tobacco?	☐	☐	_____
Alcohol?	☐	☐	_____
Non-prescribed drugs?	☐	☐	_____
Prescription medications?	☐	☐	Medication: _____ Reason: _____
Over-the-counter medications?	☐	☐	Medication: _____ Reason: _____

Were you under chiropractic care during your pregnancy? **Y N**
Whom? _____
Did you have massage therapy during your pregnancy? **Y N**
Whom? _____

History of Birth

Date: ___ /___ /___ Name of Child: _____ Date of Birth: ___ /___ /___

LABOR AND DELIVERY:

What was your first sign of labor? _____

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

How long was the 2nd stage (the pushing phase) of the labor? _____ hours/minutes

	Yes	No	
Hospital birth	☐	☐	
Name of Hospital:			_____
Physician/Midwife:			_____
Home birth	☐	☐	
Midwife:			_____
Birth Center birth	☐	☐	
Name of Birth Center:			_____
Physician/Midwife:			_____
Vaginal Delivery	☐	☐	_____
Planned C-section	☐	☐	If yes, why? _____
Emergency C-section	☐	☐	_____
Was Birth Induced	☐	☐	_____
Pitocin:	☐	☐	_____
Breaking bag of waters:	☐	☐	_____
Suppository:	☐	☐	_____
Forceps delivery	☐	☐	_____
Vacuum extraction	☐	☐	_____
Anesthesia administered	☐	☐	_____

At what point during labor was anesthesia administered? _____

What type of anesthesia was used? _____

Fetal distress	☐	☐	_____
Meconium staining	☐	☐	_____
Episiotomy/Tearing	☐	☐	_____
Head presentation	☐	☐	_____
Face presentation	☐	☐	_____
Breech presentation	☐	☐	_____

BABY'S CONDITION IMMEDIATELY AFTER BIRTH:

APGAR Scores: At 1 minute _____/10 At 5 minutes _____/10

Baby's Crying: Baby Cried Immediately After Birth ☐ Cried Strongly ☐ Weak Cry ☐
Baby Did Not Cry for _____minutes

Baby's Color: Pink all over ☐ Blue face ☐ Blue Hands/Feet ☐ Jaundice ☐

Baby's Head: Bruised ☐ Swollen ☐ Red ☐ Misshapen ☐

Baby's Activity: Arms and legs actively moving ☐ Floppy baby ☐

Signs of Trauma: Yes ☐ No ☐

Intensive Care: Was required ☐ Days in Neonatal Intensive Care Unit _____

Medication given at birth (to baby): _____
(to mom): _____

Vaccines administered: _____ Vitamin K ☐ Circumcision ☐

Tests run: _____

Birth weight: _____lbs._____oz. Birth length: _____in.

Baby home on day_____ Mom home on day _____

Breastfeeding: Latched on right away ☐ Difficulty feeding ☐ Didn't Breastfeed ☐

PATIENT INFORMATION

Date: _____
Patient Name: _____ Day Phone:_____
Address: _____ Night Phone:_____
City: _____ State:____ Zip:_____ Cell Phone:_____
Date of Birth: ___/___/___ Age: _____ Patient's Social Security Number: ____ - ____ -____
E-mail Address: _____
Mother's Name: _____ Occupation: _____
Father's Name: _____ Occupation: _____
Referred to this office by: Friend/Relative Yellow Pages Insurance Company Other

INSURANCE INFORMATION

Who is responsible for this account? _____
Insurance Company: _____
Group Number: _____ ID Number:_____
Subscriber's Name: _____ Employer: _____
Date of Birth: ____/____/___ Social Security Number: ____ - ____ - ____
Relationship to patient: _____

Is patient covered by additional insurance? Yes No
Insurance Company: _____
Group Number _____ ID Number_____
Subscriber's Name: _____ Employer: _____
Date of Birth: ____/____/___ Social Security Number: ____ - ____ - ____
Relationship to Patient: _____

Name of Pediatrician: _____ Location of Pediatrician_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

I also hereby authorize Dr. _____ and whomever she may designate as assistants to administer chiropractic care as deemed necessary for _____ (name of child).

I give Dr. _____ permission to contact my child's pediatrician regarding his/her care? Yes No

_____ _____
Responsible Party Signature Relationship