McAuliffe Chiropractic Office

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:** ________