

**NEWBORN HEALTH QUESTIONNAIRE**

**Newborn to 2months**

Note: Injury to the spine during the birth process, as well as the numerous falls and accidents during childhood, could be the unsuspected cause of many health problems in children.

Today’s Date: Name of Baby:

 Preferred Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_ Sex: M F

Name of Mother: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Father: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What was the term of your pregnancy? How many children do you have?

Birth weight:

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address of Parent (if different from child): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the purpose of this appointment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any other concerns? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRENATAL HISTORY**

Note: As many childhood and adult health problems arise from pregnancy or through events occurring during labor and delivery, the following information is vital in determining the onset of illness or injury.

**During Pregnancy, Did You Have Any Of The Following?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| □ Falls | □ Motor vehicle accident | □ Near Miss MVA e.g. heavy breaking | □ High B/P | □ Diabetes |
| □ Anemia | □ Morning Sickness | □ Indigestion | □ Seizures | □ Swollen Ankles |
| □ Thyroid Problem | □ Heart Problems | □ Back Pain | □ Abnormal Bleeding | □ Were You Hospitalized |
| □ Any other Illnesses |  |  |  |  |
|  |  |  |  |  |

**During Pregnancy, Did You Use Any Of The Following?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| □ Tobacco | □ Alcohol | □ Non-Prescribed drugs e.g. Panadol/Marijuana | □ Prescription Medication | □ Over the counter Medication e.g. Cold and Flu medications |
|  |  |  |  |  |
|  |  |  |  |  |

**Circle type of birth**: Vaginal / Forceps / Vacuum / Breech / Caesarean – Planned or Emergency

Were there any problems during labor/delivery? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was there medication or anesthesia used during labor or delivery? Y / N / Unsure

How long was labor? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ did the provider use hands or forceps\_\_\_\_\_\_\_\_\_\_

(95% of all infants were born with hands on or forceps)

If yes, did he/she turn or pull the baby’s head? Y / N Unsure

Was there any visible injury to the baby after delivery? Y / N / Unsure

If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What were your Babies Apgar scores at birth? 1min\_\_\_\_\_\_ 5min\_\_\_\_\_\_ 10min\_\_\_\_\_\_\_

**FEEDING HISTORY**

Is baby breastfed? Y / N

If no, for how long was baby breastfed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_weeks/mths

Does baby have any feeding difficulties?

Does baby have a one side breastfeeding preference? \_\_\_\_\_\_\_\_\_\_ Preferred breast Left/Right

Is baby formula fed? Y / N

Which Formula or other Milk Source? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does baby frequently spit-up after feeding?

**SLEEPING PATTERNS**

Does baby go to sleep easily?

Does baby have a preferred sleeping position?

Does baby cry if you change this sleeping position?

**HEALTH HISTORY**

Does 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 his/her head and neck backwards?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does baby cry or become irritable during a diaper change? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has baby ever had a fever? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has baby had any falls? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your baby ever been involved in an automobile accident? Y / N / Unsure If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any other traumas, surgeries, and/or hospitalizations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your baby vaccinated? Y / N If yes: Full Schedule / Partial

Did your child experience any immediate or delayed adverse reactions? Y / N Unsure If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your Baby on any medication or supplements? Y / N / Unsure If Yes, Please explain: \_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you concerned about any developmental delays? Y / N / Unsure If yes, please explain: \_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do any family members have the same or similar health conditions? If yes, please list the family member and explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# About Your Child’s Care

There are three phases of care that Chiropractic patients often go through. The first is **Initial Intensive Care** which corrects the most recent layer of Spinal and Neurological damage (**VSC Vertebral Subluxation Complex**). This care often reduces or eliminates the symptoms. Then begins **Rehabilitative Care** which corrects the years of damage that occurred when there were few symptoms. And finally, Chiropractic offers a genuine approach to **Wellness Care**. All of these options will be explained at your report of findings. Then you’ll be able to begin a course of care that fits your goals.

# Your appointments at our Centre are important to you and others. If you’re unable to keep your appointment, the courtesy of 24 hours notice will enable us to schedule someone else in your place. Therefore, in fairness to all our valued clients, a standard adjustment fee may be imposed on missed appointments.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_