BalanceChiropractic

NEWBORN HISTORY
Birth to 2 months
AND
PREGNANCY HISTORY

Mother's Name _____ How Many Children Do You Have?_____
What was the term of your pregnancy? _____ weeks

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

	Yes	no	
Falls?	☐	☐	_____
Motor Vehicle Accident?	☐	☐	_____
High B.P.?	☐	☐	_____
Diabetes?	☐	☐	_____
Anemia?	☐	☐	_____
Morning Sickness?	☐	☐	_____
Indegestion?	☐	☐	_____
Seizures?	☐	☐	_____
Swollen Ankles?	☐	☐	_____
Thyroid Problems?	☐	☐	_____
Heart Problems?	☐	☐	_____
Back Pain?	☐	☐	_____
Abnormal Bleeding?	☐	☐	_____
Were you Hospitalized?	☐	☐	_____
Any other Illnesses?	☐	☐	_____

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

	Yes	no	
Tobacco?	☐	☐	_____
Alcohol?	☐	☐	_____
Non-prescribed drugs?	☐	☐	_____
Prescription Medications?	☐	☐	_____
Over-the-Counter Meds?	☐	☐	_____

BalanceChiropractic

BIRTH HISTORY

LABOR AND DELIVERY

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

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

	Yes	no	
Hospital birth	☐	☐	_____
Home birth	☐	☐	_____
Midwife assisted	☐	☐	_____
Vaginal Delivery	☐	☐	_____
Planned C-section	☐	☐	_____
Emergency C-section	☐	☐	_____
Was Birth Induced (Pitocin)	☐	☐	_____
Forceps delivery	☐	☐	_____
Vacuum extraction	☐	☐	_____
Anesthesia administered	☐	☐	_____
Fetal distress	☐	☐	_____
Meconuim staining	☐	☐	_____
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 ____ 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 ____ Days in Neonatal Intensive Care Unit ____

Medication given at birth? _____ Vaccines administered _____

Birth weight ____lbs Birth length ____ins / cms Baby home on day _____

Patient Name: _____ Date of Birth: _____ Doctor Signature: _____

BalanceChiropractic

NEWBORN HISTORY

Birth to 2 months

Today's Date _____

Patient's Name _____ Sex: M F
Date of Birth _____ Age ___

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? ☐ ☐ _____

How many hours does your baby sleep between feeds? During day _____ At Night _____

Does baby have a preferred sleeping position? ☐ ☐ _____

Does baby cry if you change their sleeping position? ☐ ☐ _____

Is baby being formula fed? ☐ ☐
If no, for how long was baby breast fed _____ weeks/months

Does baby have a one sided breast-feeding preference? ☐ ☐ Preferred breast Left / Right

Is baby formula fed? ☐ ☐ Which formula or other milk source? _____

Does baby frequently spit-up after feeding? ☐ ☐ _____

Does your 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 baby been in a car accident or near-miss? ☐ ☐

_____

Has baby had any other trauma? ☐ ☐

_____

Has your baby been vaccinated? ☐ ☐

_____

Do you have any other concerns you wish to discuss? ☐ ☐

_____

CONSENT TO TREAT

Being the parent or legal guardian of this child, I herby authorize this office and its doctors to examine and administer care to my son / daughter named_____ as the examining / treating doctor deems necessary.
I understand and agree that I am personally responsible for payment of all fees charged by this office for such care.
Parent's Name _____ Signature _____
Date _____Witnessed by _____