CHIROPRACTIC NEWBORN EVALUATION
Birth to 2 Months of Age

Date of Exam: ___/___/____
Patient's Name (child): _____ Sex: _____ Birthday: ___/___/____

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

How may hours does your baby sleep between feedings? During the Day: _____ At Night: _____

Yes	No	
☐	☐	**Does your baby go to sleep easily? _____**
☐	☐	**Does your baby have a preferred sleeping position? _____**
☐	☐	**Does baby cry if you change this sleeping position? _____**
☐	☐	**Does baby have any feeding difficulties? _____**
☐	☐	**Is baby breast-feeding? _____If no, for how long was baby breast fed?_____**
☐	☐	**Does baby have a one-sided breast–feeding preference? Y N Right Left**
☐	☐	**Is baby fed formula? Y N Which formula or other milk source? _____**
☐	☐	**Does baby frequently spit-up after feeding? _____**
☐	☐	**Does your baby cry a lot? Y N For how many hours each day? _____**
☐	☐	**Does baby pass a lot of intestinal gas? _____**
☐	☐	**Does baby have a preferred head position? Y N What? _____**
☐	☐	**Does baby cry or become irritable during a diaper change? _____**
☐	☐	**Has baby ever had a fever? Y N _____**
☐	☐	**Has baby had any falls? Y N _____**
☐	☐	**Has baby been in a car accident or near miss? Y N _____**
☐	☐	**Has baby had any other trauma? Y N _____**
☐	☐	**Has your baby been vaccinated? Y N _____**
☐	☐	**Any other concerns you wish to discuss? Y N _____**
		_____

Doctor's Signature: _____