Cranial Patient History

Today's Date: _____

Patient's Name: _____ DOB: ____/____/_____

☐ Male ☐ Female Parents/Caregivers Name: _____

Was the pregnancy normal: ☐ Yes ☐ No _____

☐Full Term ____weeks ☐Premature ____ weeks

Was the baby in the NICU? ☐ No ☐ Yes, how long? _____

Birth weight_____ Birth length_____

Type of birth: ☐Vaginal ☐C-section ☐Breech ☐Forceps ☐Suction

Complications with the delivery? ☐No ☐Yes _____

Other medical concerns? _____

_____

_____

Have there been any diagnostic tests of the baby's head? ☐ No ☐ Yes

If yes, what kind of tests? ☐X-ray ☐CAT scan ☐MRI ☐Other

Did your child's head look normal at birth? ☐No ☐Yes

Who first noticed the asymmetry? _____ At what age? ____months

Has the head shape changed since you first noticed the asymmetry?

☐Worse ☐Improved ☐Stayed the same

What position does your baby sleep in? ☐Back ☐ Stomach ☐Left side ☐Right side ☐_____

Does the baby prefer to look to one side over the other? ☐No ☐Yes, what side? ☐Left ☐Right

Has Torticollis been diagnosed? ☐Yes ☐No

Has there been any intervention to correct the head shape?

☐PT/OT Repositioning ☐Tummy time ☐Neck stretches ☐Propping w/ sleeping

Has there been any surgery to correct the head shape? ☐No ☐Yes