CRANIAL ASYMMETRY QUESTIONNAIRE

Date: _____

Name: _____

☐ Male ☐ Female

DOB: _____

MR#: _____

Circumference:	_____cm	R Ant – L Post:	_____cm
ML:	_____cm	L Ant – R Post:	_____cm
AP:	_____cm	Cranial Vault:	_____mm
Cephalic Ratio:	_____%	CVAI:	_____%
Rt Trag-Sn	_____mm	Lft Trag-Sn	_____mm

☐ Plagiocephaly ☐ Brachycephaly ☐ Asymmetrical Brachycephaly ☐ _____

For Office Use Only- To Be Completed By Healthcare Professional

Caregiver Name(s): _____ Child's Age: _____ Month _____ Weeks

1. Was the child: ☐ Full Term ☐ Premature _____ weeks
2. Birth Type (check all that apply): ☐ Multiple ☐ Breech ☐ Assisted ☐ Vaginal ☐ Cesarean
3. Were there any complications with the pregnancy or delivery? ☐ NO ☐ YES (explain)

   _____
4. Did your child's head look normal at birth? ☐ NO ☐ YES
5. At what age did you first notice a flat spot? _____
6. Have you been practicing active repositioning (turning baby's head/body)? ☐ NO ☐ YES
7. Does your child have any neck tightness or torticollis? ☐ NO ☐ YES ☐ UNSURE
8. Does your child favor looking to one side? ☐ NO ☐ YES: RIGHT / LEFT (Circle one)
9. Have you, a physical therapist, or early intervention used exercises to stretch your baby's neck?
   ☐ NO ☐ YES – we have been stretching since _____
10. What does your child sleep in? ☐ Crib ☐ Bassinette ☐ Co-Sleeper ☐ Magic Merlin Suit® ☐ Rock-N-Play®
    ☐ Other_____
11. What is your child's preferred sleeping position? ☐ Back ☐ Stomach ☐ Right Side ☐ Left Side
12. How long does your child tolerate tummy time?_____minutes, approximately _____times/day
13. Has your child's head shape: ☐ Worsened ☐ Improved ☐ Unchanged
14. Is there a family history of abnormal head shapes? ☐ NO ☐ YES_____
15. Does your child have any other medical conditions? _____

    _____
16. Describe who lives in the household with the child. _____