Cranial Asymmetry Questionnaire

Child's Name: ______________________________ Caregiver's Name(s): __________________________

☐ M ☐ F DOB: ______________________ Child's Age: _____ Months ______ Weeks

1. Who referred you for the cranial evaluation? ___________________________________
2. My child was born: ☐ Full Term ☐ Premature ______ weeks
3. Birth Type: (check all that apply) ☐ Multiple ☐ Breech ☐ Assisted ☐ Vaginal ☐ Cesarean
4. Were there any complications with the pregnancy or delivery? ________________________________

   ____
5. Does your child have any other medical conditions? ____

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6. Did your child's head look normal at birth? ☐ No ☐ Yes
7. At what age did you first notice a flat spot? ____
8. Who first noticed the abnormal head shape? ☐ Family ☐ PT ☐ Doctor ☐ ______________
9. Does your child favor looking to one side? ☐ No ☐ Yes – my child favors looking to the Right / Left
10. Does your child have any neck tightness or torticollis? ☐ No ☐ Yes
11. Have you or a physical therapist used exercises to stretch your baby's neck? ☐ No ☐ Yes – have been stretching since ____
12. What position does your baby like to sleep in? ☐ Back ☐ Stomach ☐ Left Side ☐ Right Side
13. Does your child practice tummy time? ☐ No ☐ Yes Hours per day: __________________________
14. My child's head shape has: ☐ Worsened ☐ Improved ☐ Unchanged
15. Other comments: ____

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Please circle: I **do** / **do not** consent to have photos taken for clinical documentation in communication with my care team including, but not limited to, physical and occupational therapy and physician(s).

______________________ ______________________ ______________

Signature Print Name/ Relationship Date