Great Steps
Orthotics & Prosthetics

CRANIAL INFORMATION

Child's Name: _____ Parent's Name: _____

Please list all sibling names, their ages and whether they were treated for plagiocepha (cont. on back if needed)

Sibling Names	Age	√ if treated	√ if N/A

Birth Information

Date of birth _____ Birth Weight _____ Birth Length _____

If birth was premature, please indicate number of weeks early _____

What type of delivery was performed? ☐ C-section ☐ Vaginal ☐ Vacuum Assist

Indicate any pregnancy or delivery complications _____

Indicate any special care received following delivery _____

Head Shape

Was this child's head shaped normally at birth? ☐ Yes ☐ No ☐ Unsure

If yes, at what age was a difference in head shape noticed? _____

Do you think there is a problem with this child's head shape? ☐ Yes ☐ No ☐ Unsure

If so, how would you rate it? ☐ Mild ☐ Moderate ☐ Severe

Is the head shape similar to any extended family member? ☐ Yes ☐ No ☐ Unsure

If yes, whom? _____

Diagnostic

Has this child been evaluated by a specialist? ☐ Chiropractor ☐ Physical Therapist ☐ Cranial Facial

If so, whom? _____

Which diagnostic procedures have been done? ☐ None ☐ CT Scan ☐ X-ray ☐ MRI

Has Craniosynostosis been identified? ☐ Yes ☐ No ☐ Unsure

Has neck tightness or torticollis been an issue? ☐ Yes ☐ No ☐ Unsure

Rate this child's achievement of developmental milestones. ☐ Ahead of Avg ☐ On Time ☐ Behind Avg

Positioning

In what position does this child prefer to sleep? _____

Is this child being actively repositioned? ☐ Yes ☐ No ☐ Unsure

This child usually… ☐ Tolerates new position ☐ Returns to preferred position

Is supervised tummy time provided daily? ☐ Yes ☐ No ☐ Unsure

The past month, this child's head shape has ☐ Stayed Same ☐ Become Worse ☐ Become Better

Are you ready for this child to begin treatment using an FDA Regulated cranial remolding Orthosis (helmet) at this time? ☐ Yes ☐ No ☐ Unsure

Parent/Guardian Signature **Date**