# 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? _____

   _____
6. Did your child's head look normal at birth? ◯No ◯Yes – At what age did you first notice a flat spot? ____

   _____
7. Who first noticed the abnormal head shape? ◯Family ◯PT ◯Doctor ◯_____
8. Does your child favor looking to one side? ◯No ◯Yes – my child favors looking to the ◯Right ◯Left
9. Does your child have any neck tightness or torticollis? ◯No ◯Yes
10. Have you or a physical therapist used exercises to stretch your baby's neck? ◯No ◯Yes – have been stretching since _____
11. What position does your baby like to sleep in? ◯Back ◯Stomach ◯Left Side ◯Right Side
12. Does your child practice tummy time? ◯No ◯Yes Hours per day: _____
13. My child's head shape has: ◯Worsened ◯Improved ◯Unchanged
14. Other comments: _____

    _____

**Please check: ◯ I do ◯ I 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 |