CRANIAL REMOLDING HISTORY FORM

Patient Name:

DOB:

Gender: Male

Baby's Weight:

Race: Asian/Pacific Islander

Baby's Height:

Hispanic or Latino?: Not Hispanic/Latino

Current Age:

Age Adjusted (if premature):

Birth History

Is your baby a twin? Not a twin

Type of Birth: Vaginal

Birthing Details: None

Gestation at Birth (How far along were you?): weeks

Describe any complications that occurred during labor/delivery:

Was the baby hospitalized for any reason:

Was the baby in the NICU? No

If yes, for how long:

General Health

Does the baby have any of the following:

- ☐ Torticollis
- ☐ Hearing Impairment
- ☐ Vision Impairment
- ☐ Feeding Issues (G or J Tube)
- ☐ Sensitive Skin
- ☐ Eczema
- ☐ Cradle Cap
- ☐ Known Allergies:

Plagiocephaly/Brachycephaly

Did your baby's head appear normal at birth? Yes

When did you first notice the flattening/asymmetry of your baby's head?

Has your baby been evaluated by a neurosurgeon? No

Name of Neurosurgeon:

Last Seen:

Upcoming Appointment:

Has your baby has any physical or occupational therapy? No

Name of Therapist/Practice Name:

How Often Seen?

Developmental Milestones

Roll from stomach to back? No

Pulling up to stand? No

Crawling? No

Roll from back to stomach? No

Sitting Independently? No

Walking? No

Any Additional Information: