



Specialized Services
for Children & Youth
Together Is Better

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REHABILITATION
CENTRE FOR
CHILDREN



Plagiocephaly and Torticollis Intake Form

Child's Name: _____

Number of weeks at Birth (Term = 40 weeks): _____ Birth Weight: _____

Baby's Age: _____

Type of Birth:

- Single or Multiple
 Head-down or Breech
 Caesarean or Vaginal
 Forceps Suction or Not Applicable

Were there any problems during the delivery/pregnancy No Yes
If yes, please explain: _____

Are you concerned about your baby's head shape?..... No Yes
If yes:

- When did you become concerned? _____
- Has your baby's head shape improved? No Yes

Does your baby prefer to keep his/her head to one side or the other? No Yes
If yes:

- At what age did you first notice this? _____
- Which side: Right Left
- Has your baby's preference to keep his/her head to one side improved since you first noticed it?..... No Yes

Have you tried repositioning your baby? No Yes
How? Propping with pillows Tummy time
 Other: _____

Does your baby do any tummy time during the day?..... No Yes
If yes, how many minutes? _____

Has your baby been treated by any other health care professionals? No Yes

Other important medical information: _____
