



Plagiocephaly and Torticollis Intake Form

Baby's Name: _____ Baby's Age: _____

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

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? _____

Sleep/Nap Surface: Crib Bassinette Bed Swing Other: _____

Has your baby had difficulty with feeding? Explain: _____

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

- Doctor/Specialist: _____
- Private Physiotherapist Chiropractor
- Osteopath Massage Therapist



Specialized Services
for Children & Youth
Together Is Better

Rehabilitation Centre for Children
1155 Notre Dame Avenue
Winnipeg, MB, Canada R3E 3G1
Tel: (204) 452-4311 Fax: (204) 477-5547
Web: www.rccinc.ca email: info@rccinc.ca

REHABILITATION
CENTRE FOR
CHILDREN



----- To be filled out by Physiotherapist-----

Concurrent care:

- Provider name and designation: _____
- Name of clinic: _____
- Phone: _____ Fax: _____
- Treatment provided: _____

- Provider name and designation: _____
- Name of clinic: _____
- Phone: _____ Fax: _____
- Treatment provided: _____

Additional important medical information:
