Rehabilitation Centre for Children

SSCY Centre
1155 Notre Dame Avenue
Winnipeg, MB, Canada R3E 3G1

T (204) 452-4311
F (204) 477-5547

rccinc.ca

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

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REHABILITATION
CENTRE FOR
CHILDREN

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

Concurrent care:

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

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

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Additional important medical information:

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