CUSTOM ORTHOTICS
OF LONDON INC.
C.B.C.P.O. Certified

Cranial In-Take Form

Patient's Name: _____ Parent's Name: _____
Age: _____ Date of Birth: _____ Weight at birth: ___lb____oz
Was the patient Full Term at birth: Yes/No If **No** how many weeks_____

Were there any Complications in delivery: Yes/No
If **Yes** what were the complications _____
_____
Was the patient in the NICU: Yes/No

Who first noticed the head shape: _____
At what age did you notice the head shape: _____

What have you noticed: Flat Spot_____ Forehead Bossing_____
Eye Asymmetry_____ Ear Asymmetry_____ Facial Asymmetry_____
Elevated Cranial Vault_____
Has it changed since first noticed it? Yes/No If **Yes** How: _____

What diagnostic procedures have been done? (Check all that apply)
Clinical exam of the head_____ X-Ray _____ CT Scan_____ MRI_____
Has the baby had surgery for Craniosynostosis: Yes_____ No_____
If yes date of surgery: _____

What Intervention technique(s) have you tried with your infant?
Physio_____ Name of Therapist_____
Tummy Time_____ Repositioning_____ Exercises for Torticollis_____
Mimos Pillow_____

Is the patient able to: (check all that apply)
Sit Independently_____ Crawl_____ Pull to Stand_____ Cruise_____
Walk_____