VPO
Valley Prosthetics & Orthotics Inc.

Patient Information Sheet: Cranial Remolding Helmet

(Please answer the following to ensure effective treatment design for your child.)

Patients Name: _____ Date: _____

DOB: _____ M/F HT ____ WT____ Weeks of Pregnancy:_____

What type of birth: (please circle all that apply)

1st Child Multiple Head-down Forceps Breech Suction Cesarean Vaginal

Were there any problems before/after delivery? _____

Does your baby have any neck tightness? Yes No If yes, which side? Right / Left / Unsure

Have you or a PT used exercises to stretch your baby's neck before seeking treatment? Yes No

If Yes: When did you start treatment: _____

Therapist Name/Company: _____ Phone: _____

What position does your baby to sleep in? _____

Did your child have to spend long periods of time in one position for the first weeks/month of life? Yes No

If yes, explain: _____

Did your child's head appear to be normally shaped at birth? Yes No

At what age did you first notice the abnormal shaping of your child's head? _____

Do you have other children? Yes No

If yes, did any of your other children have abnormally shaped heads? Yes No

_____

Parent or Guardian Signature Date