

**Torticollis Insert**

Patient Name: \_\_\_\_\_

Date of Evaluation: \_\_\_\_\_

Know Uterine Abnormalities? **Yes / No** Describe: \_\_\_\_\_

First Child? **Yes / No** **Single / Multiple** Birth: Twin A / Twin B Other: \_\_\_\_\_

Fertility Treatment: **Yes / No** Medication: \_\_\_\_\_

Diagnostic Test: **X-Ray MRI CT Scan US**

Visual Problems: \_\_\_\_\_ Hydrocephalus: \_\_\_\_\_

Lie of infant at birth: Vertex / Breech / Transverse / Other: \_\_\_\_\_

Delivery: Vaginal / C-Section / Forceps / Vacuum / Nuchal Cord / Other: \_\_\_\_\_

How long did you push? \_\_\_\_\_ Was infant active? **Yes / No**

Did the infant seem stuck in one position for the last part of pregnancy? **Yes / No**

How many weeks was the infant stuck? Vertex / Breech / Transverse \_\_\_\_\_ weeks

Any other children with tight neck muscles and / or misshapen head? **Yes / No**

Did your infant have trouble feeding? **Yes / No** (breast left / right; bottle feeding)

Jaundice? **Yes / No** Reflux? **Yes / No** Medication: \_\_\_\_\_

Did your infant have a normal head shape at birth? **Yes / No** If no, describe: \_\_\_\_\_

Who noticed misshapen head? \_\_\_\_\_ What age? \_\_\_\_\_

Time child spends in car seat carrier per day: \_\_\_\_\_ Type used: \_\_\_\_\_

Time child spend in swing per day: \_\_\_\_\_

Other infant sitting devices used and time spend per day: \_\_\_\_\_

Time child spends on back daily: \_\_\_\_\_ Time child spends on belly daily: \_\_\_\_\_

Does your infant have a head tilt preference: **Left / Right** Rotation Preference: **Left / Right**

Do you notice any facial asymmetry? **Yes / No** Describe: \_\_\_\_\_

Congenital anomalies:

Hip dysplasia / hip subluxation left / right

Fractured clavicle left / right

Forceps abrasion left / right

Facial palsy left / right

Brachial plexus injury left / right

Cephalohematoma: Parietal left/ right, small / medium / large

Occipital left / right, small / medium / large