Cranial Information Form
Short Hills Cranial Center
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History:

1. ID _____ Today's Date_____ Date of Birth _____
2. Primary specialist _____
3. Birth weight _____ length _____ number of weeks at birth _____
4. Type of birth Vaginal C-section breech forceps suction
5. Prolonged time in birth canal unusual position of baby in the uterus
   If yes, note the position _____ single child multiple
6. Were there any problems during the delivery? _____
7. Did the child's head appear to be normally shaped? _____
8. Has a craniofacial specialist ever evaluated the child? Yes No
   Name of specialist _____
9. What diagnostic procedures have been completed on the baby?
   Clinical exam of the head X-ray CT scan MRI
10. Has the baby had surgery for craniosynostosis? Yes No
    If yes, note date of surgery _____ What was the involved suture? _____
    Procedure _____

Patient Evaluation/Positioning

1. Active (AROM) & Passive (PROM) range of motion is within normal limits for tilt and rotation Limitation in PROM rotation right PROM rotation left PROM tilt right PROM tilt left Limitation in AROM rotation right AROM rotation left AROM tilt left AROM tilt right
2. Did the baby spend long periods of time in one position I the first few mnths?
   Yes No

If yes, was this related to positioning to prevent reflux or other medical conditions?

If yes, what was the medical condition? _____

3. Does the baby spend more than 4 hours/day in infant carrier car seat stroller swing

   Brand of car seat _____ brand of stroller _____
4. In what position does the baby prefer to sleep? _____
5. Developmental milestones: check all that apply based on a clinical observation or caregiver report.

   Centers head in midline in sitting rolls from front to back rolls from back to front sits independently for 5 minues pushes chest off the floor gets to hands and knees reciprocal crawling army crawl cruises takes steps walks independently
6. hand grasp: symmetrical right grasp stronger left grasp stronger

Therapeutic Intervention

7. Therapy program Yes No If yes, how many times/week ___ still in therapy? Yes No
8. Repositioning home program Yes No Age at time program started _____
9. Who provided the program Therapist Pediatrician Caregiver Specialist
10. Has your baby been diagnosed with any vision problems? Yes No
11. Has your baby been diagnosed with any feeding or jaw problems? Yes No
12. Has your baby been diagnosed with any hearing problems? Yes No

Parent Assessment

1. Parent assessment of the head shape at first appointment:
   date_____Normal 1 slightly abnormal 2 moderately abnormal and acceptable 3 Moderately abnormal and unacceptable 4 Severely abnormal and unacceptable 5
2. Parent's assessment of the head shape at the end of treatment:
   date _____ Normal 1 slightly abnormal 2 moderately abnormal and acceptable 3 moderately abnormal and unacceptable 4 severely abnormal and unacceptable 5
3. Parent satisfaction wih head shape at the end of treatment: Date: _____
   Extremely satisfied 1
   Moderately satisfied 2
   Mildly satisfied 3
   Mildly dissatisfied 4
   Moderately or extremely dissatisfied with the head shape 5

I give my permission for this data to be used for clinical studies or presentations. This data will be maintained in a HIPAA compliant database and will not be identifiable.

Signature of guardian _____date _____

Signature of orthotist _____date _____

I give my permission for Short Hills Cranial Center to use my baby's clinical pictures for clinical studies, presentations, marketing or other programs pertinent to the StarBand.

Signature of Guardian _____date _____