dell children's
medical center of central texas
A member of the Seton Family of Hospitals

Craniofacial Center
Positional Parent Form

The Craniofacial Center at Dell Children's Medical Center

Parents: Please complete this if your child is here to be evaluated because of the shape of the skull.
Please either circle or describe:

1. Are you here because your baby's misshapen head is caused by the way your baby sleeps?
No Yes Don't Know

2. Are you here because your baby's misshapen head is because there is a problem with a joint in the skull?
No Yes Don't Know

3. *How old is your baby?*

4. Father's age at time of birth? *Mother's age at time of birth?*

5. How many children in the family? *Girls?* *Boys?*

6. *Were there any problems during the pregnancy and/or delivery?*

Was it a vaginal delivery? Yes No
Was it a C-Section? No Yes
Did you have pain in the ribs when you were carrying your child? No Yes
Did you have pain in the pelvis when you were carrying your child? No Yes

7. Hospital where the child was born? _____

8. *Was your baby born premature?* No Yes
If yes, how many weeks? _____

9. What was the birth weight? _____Lbs.

10. *What was the shape of the head when the baby was born?* Normal Cone-shaped Abnormal

11. At your first visit with the pediatrician, did he/she discuss with you about:
About repositioning your baby? No Yes
About 'tummy' time? No Yes

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12. Does your baby have any other medical problems?

If yes, please describe:

_____

_____

13. *Does your baby have a stiff neck or wry-neck (torticollis)?* No Yes

If yes: At what age was this noted? _____

Which side of the neck Right Left

Has it been treated with neck exercises? No Yes

Has it gotten better? Yes No

14. *Questions about motor development: Can your baby:*

Hold his/her head up?	No	Yes	At what age: _____
Roll over?	No	Yes	At what age: _____
From tummy to back?	No	Yes	At what age: _____
From back to tummy?	No	Yes	At what age: _____
Sit up?	No	Yes	At what age: _____
Crawl?	No	Yes	At what age: _____
Pull to stand?	No	Yes	At what age: _____
Walk?	No	Yes	At what age: _____

15. *Questions about sleeping habits:*

1. For how many months did your baby sleep on his/her back? _____
2. Does your baby still prefer sleeping on: the back the right side or the left side
3. What percentage of the time do you find your baby still sleeping on the side that is flat:

Circle one: 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

4. How many hours does your baby sleep (total number of hours night and day)? _____
5. How much time does your baby spend on his/her stomach during the day? _____
6. At what age did you start actively repositioning your child? _____
7. How many weeks or months have been actively repositioning your child? _____
8. Have you seen any improvement? None Some A Lot

_____ _____

Parent Signature Date

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