Occupational/Physical Therapy Torticollis Evaluation

EVALUATION PERIOD: _____ to _____

ADDITIONAL SERVICES RECOMMEDED BY THE THERAPIST COMPLETING THIS EVALUATION:

☐ **SPEECH-LANGUAGE THERAPY EVALUATION**

☐ **PHYSICAL THERAPY EVALUATION**

Patient:	Date of Birth: Age:
PCP:	Parent/Guardian:
PCP Address:	Phone:
	Diagnosis:
PCP Phone:	Medicaid # (if applicable):
PCP Fax:	Date of Evaluation:

Pertinent History:

Prenatal/Birth History:_____

Breech:_____C-Section:_____Vacuum/Forceps:_____Intrauterine Constraint:_____

Birth Weight:_____Gestational Age:_____ Birth Order: 1_____ 2_____ 3_____ 4_____ Other:_____

Age Torticollis Diagnosed:_____ By Whom:_____

Cervical X-rays/Ultrasound: Yes / No Results:_____

Hip X-Rays/Ultrasound: Yes / No Results:_____

Other Medical Problems/ Consultation:_____

_____

Feeding Problems/Reflux:_____

Comments:_____

_____

_____

Plagiocephaly:

Occipital:	Right/Left	Flat/Bossing	Ear Position:	Symmetrical / R forward / L forward
Frontal:	Right/Left	Flat/Bossing		Level / R High / L High
Parietal:	Right/Left	Flat/Bossing	Eye Position:	Level / R High / L High
Zygomatic Arch:	Right/Left	Flat/Bossing	Jaw Shift:	None / R / L

Comments:_____

_____

Cervical Range of Motion:

Appearance: Tilts head to: Right / Left Assessed in: Supine_____ Sitting_____

Rotates head to: Right / Left Supported Sitting_____

	ACTIVE		**PASSIVE**	
	Right	Left	Right	Left
Rotation:	_____	_____	_____	_____
Lateral Flexion to:	_____	_____	_____	_____
Resting/Postural Tilt:	_____	_____	_____	_____

Orthopedic Concerns:

(SCM Mass Yes / No
Skin Condition Yes / No
Trunk Asymmetry Yes / No
Elevated Pelvis Yes / No
Hip Dysplasia Yes / No
Thigh Creases Equal / Unequal
Hip Abduction (in flexion)
Talipes Equinovarus: Yes / No
Metatarsus Adductus: Yes / No
Other:_____

Comments:

_____
_____
_____
_____
_____
_____
ROM:_____
_____
_____

Motor Development:

Primitive Reflexes: Integrated / Present / Age Appropriate:_____
Neck Strength: Extension (Prone):_____
Flexion (Pull to Sit):_____
Visual Screen: Tracks through available ROM: Yes / No:_____
Prone Exposure / Tolerance:_____
Positioning Equipment used at home:_____
Developmental Skills Assessed with: Denver II AIMS Peabody II Clinical Observation
Skills Average for _____ month old child
Comments:_____

Caregiver Training and Treatment Plan:

_____
_____
_____

Assessment:

_____
_____
_____
_____

Goals: Time Frame:

LTG #1:_____
STG:_____
STG:_____
LTG #2:_____
STG:_____
STG:_____
LTG #3:_____
STG:_____
STG:_____

It is recommended that the above stated patient receive occupational/physical therapy (circle):

- □ Duration: 6 months (unless otherwise stated) Other:_____
- □ Frequency:_____ times per week Other:_____
  An additional visit may be used 1x per month for COTA supervision as needed.
- □ Treatment Sessions up to30 minutes.
- □ Treatment Sessions 30 – 60 minutes are medically necessary due to:_____
  _____.
- □ Therapy is not recommended due _____.
- □ A re-evaluation is recommended in_____.

_____ _____ _____
Therapist Name (print) Therapist Signature Date

_____ _____ _____
Physician's Signature Date Medipass Auth. Number (if applicable)