Skill
Builders
Speech Language and Occupational Therapy Services

Annandale
7617 Little River Turnpike
Suite 310
Annandale, VA 22003

McLean
1481 Chain Bridge Road
Suite 102
McLean, VA 22101

Tel: (703) 941-7757
Fax: (703) 941-0587

New Client Packet

Table of Contents

Page(s)

Dear Parents 2 – 3

Occupational Therapy Services

Fee Information

✔ Release of Information and Receipt of Policies Form 4

General Office Policies 5

Payment and Cancellation Policies 6 – 7

Sickness Policy 8

✔ OT Case History Form 9 – 22

Directions to Skill Builders 23

✔ Please fill out these forms and mail them to Bea Bruno prior to your first session at Skill Builders.

Thank you!

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Dear Parent,

Thank you for calling Skill Builders. Skill Builders is a pediatric occupational therapy and speech therapy private practice, owned by Cari Syron, MA, CCC/SLP. Our OT department specializes in sensory processing dysfunction, and utilizes a sensory integration approach in the treatment of sensory motor problems. Therapy is provided in a warm, supportive environment with continual opportunity for information exchange with the family. Goals are outlined by the occupational therapist (O.T.), but are developed with input from the parents regarding your goals for your child.

Unless recently secured from another facility or the school system, O.T. services are initiated with a full evaluation. There are several options for evaluation and the choice is made according to the specific age and needs of the child.

The standard OT evaluation at Skill Builders is used with all children aged five years and younger, and is the typical evaluation that we use with older children, as well. This evaluation takes approximately 1 ½ hours and provides information in the following areas: fine and gross motor developmental levels, visual-motor control (primarily for pencil/paper work), visual perception, and sensory motor skills. The child's sensory integration status is assessed through clinical observations and the parent completion of a sensorimotor history (provided prior to the evaluation).

Consultations provide non-standardized information about a child's sensory or handwriting skill levels, and are completed in one hour. A short written report is provided, with initial home program suggestions included. Consultations are appropriate for children aged 6 years and older. A sensory consultation is recommended when concerns are focused in sensory areas (with no other remarkable motor control issues noted). Parent completion of a short sensory-motor history and therapist observations are used to gather information and to create initial "sensory diet" suggestions. Handwriting consultations are useful when concerns are focused on writing skill acquisition (and no other remarkable sensory or motor concerns are noted). This one-hour consultation session checks fine motor, visual-motor, postural control and letter formation skills needed for efficient writing ability. Consultations are provided by registered, licensed occupational therapists at Skill Builders.

The Sensory Integration and Praxis Tests (SIPT) are also administered at Skill Builders. Should this test battery prove to be the most beneficial for the child (ages 4 through 9 years), then it is scheduled on two separate days, requiring approximately 1 ½ hours on each day. This battery of tests provides in-depth information regarding the child's visual perceptual abilities, somatosensory skills (tactile, muscle and joint perception), praxis (motor planning and smooth execution of unfamiliar motor tasks) and sensorimotor status. The SIPT is useful when a sensory integration "diagnosis" is needed. The SIPT includes a written report and a parent/therapist conference for discussion of results.

Close contact with speech-language pathologists offers one more evaluation option. Should there be additional concerns regarding speech, auditory or language skills, a speech/language evaluation is possible at either the Annandale or McLean office.

Plans for follow-up intervention are made once the evaluation results have been discussed. The recommendations vary according to the child's needs. Some children start out with twice weekly attendance, some once a week, and sometimes the child's progress is monitored through home programming and/or monthly visits to the clinic.

Typically, follow-up OT sessions are 50 minutes in length, with activities designed to develop the child's "internal sense of control" over his/her own movement abilities. The intervention should be fun for the child. Difficulties with body awareness, muscle tone, and responsiveness to touch and movement can hold functional implications for mature movement and social skills. Many times, learning difficulties at school can be traced back to difficulties at a more "foundational" sensory motor level.

To better facilitate caseload management and services, Skill Builders maintains the following fee schedule and policies:

- Standard OT evaluation and report - $550.00
- Complete SIPT battery, parent conference and report (4-9 yr olds only) - $800.00
- Handwriting consultation - $250.00
- Sensory consultation - $250.00

- Payment in full is expected at the time of the initial evaluation.

- Fees for follow-up OT sessions are $120.00 for each "50 minute" hour, as recognized by insurance companies. The therapist needs time to write a brief progress note, return phone calls and prepare for the next child during the remaining 10 minutes. Time for therapist/parent contact is incorporated into the 50-minute session. Should more lengthy conversations be needed, your therapist may be called at the office. Parent conferences are typically scheduled annually, but can be arranged, as needed, and are billed at the $120.00 session rate.

Again, thank you for your phone call. We at Skill Builders look forward to talking with you at your convenience.

Sincerely,

Virginia R Kane, MS, OTR/L

Virginia Kane, M.S., O.T.R./L.
OT Director

Skill Builders

Speech Language and Occupational Therapy Services

RELEASE OF INFORMATION

I, ________________, hereby grant permission to Skill Builders LLC, and its employees to release information related to my child, ________'s, plan of care to:

1)___ Only the people listed below:
____
____
____

2)___ All professionals involved in my child's care, including my insurance company, for information exchange pertinent to my child's treatment program.

_________________________________ _________________

Signature of parent or guardian Date

SESSION FEEDBACK

In the interest of time, feedback following your child's treatment session is often provided in the waiting room. As other families are often present at that time, this feedback is often able to be overheard. Therefore, we ask that you check and sign one of the following options:

______________I agree to have feedback regarding my child's performance in the treatment session provided by his/her therapist in the waiting room.

______________I would prefer to have feedback regarding my child's performance in the treatment session provided by his/her therapist in a more private setting such as a treatment room. I will come to the therapy room for the final 10 minutes (or longer if requested by the therapist) of the session for feedback/collaboration.

_________________________________ _________________

Signature of parent or guardian Date

AGREEMENT OF PAYMENT

I, _________________________, agree to be responsible for charges incurred in
(Print name)
the treatment of ______________________. I fully understand that Skill Builders, LLC does not submit insurance claims and it is my responsibility to obtain and submit all necessary documentation to receive such reimbursement. Payment for services is expected at the time of service or within 15 days of receipt of statement if billed monthly. I also accept responsibility for legal fees incurred in obtaining payments should my account become delinquent.

_________________________________ ______________________

Signature of parent or guardian Date

RECEIPT OF CANCELLATION AND SICK POLICY

I also acknowledge receipt of Skill Builders cancellation and sick policy dated 09/01/10 and agree to the terms set forth.

_________________________________ ____________________

Signature of parent or guardian Date

GENERAL OFFICE POLICY STATEMENT

- ✓ Please discuss any allergies or other special accommodations for your child prior to beginning therapy so that we can do our best to meet your needs.
- ✓ We are a fragrance-free office. Please respect other patients' fragrance sensitivities by abstaining from wearing perfume or cologne when joining us in the office.
- ✓ Please do not bring food or drink into our waiting rooms. If your child must have a snack, please refrain from bringing peanut or peanut products into the office and if possible, have the snack before coming in.
- ✓ The waiting area is equipped with toys and books for your child in therapy as well as for any siblings. Please keep the waiting area reasonably quiet and assist the children with toy cleanup before leaving the office.
- ✓ Please do not leave your children unattended in the waiting area. Children are also not allowed to be unaccompanied in the hallways and/or treatment rooms.
- ✓ Snow Policy... Our offices do not automatically follow any school closings. Your therapist should be contacted regarding your desire to cancel a session due to driving conditions, and rescheduling when possible is much appreciated. Please see the full snow policy for further information
- ✓ We must keep our hallways and observation areas quiet for the sake of the children in therapy and also so that the parents watching their child, are able to hear what is happening inside the therapy room. Cell-phones, portable TVs or DVD players (without headphones) are not allowed. If bringing siblings to your child's session, please utilize the waiting area as well so as to not create additional noise or activity outside of the treatment rooms.
- ✓ Treatment rooms and the kitchen are solely for the use of our therapists. For liability reasons, children who are not directly supervised by a therapist in treatment may not be in these areas. Toys or equipment in those rooms must remain inside the therapy rooms.
- ✓ If you opt to leave the premises during your child's session, please make sure your therapist has a way to reach you (cell phone) in case of any emergency. Please return to the office at least 15 minutes prior to the end of your child's session. For example, if your child is seen from 1-2 pm, you must return to the office by 1:45pm. Your child's therapist may not have time to discuss your child's session if you are late.

PAYMENT AND CANCELLATION POLICY

(Effective 9/1/10)

Payment for therapy sessions is required at the completion of each appointment with your child's therapist. A superbill will be provided to you at that time, showing the amount due and paid, as well as all necessary coding required by insurance companies. Payments can be made by check, cash, or credit card at the Annandale or McLean office. **Therapy sessions are inclusive of the time for writing treatment notes, parent feedback, billing/payment, clean-up and preparation.** Accordingly, direct treatment time with your child for a one-hour session would be 45-50 minutes, 35-40 minutes for a 45 minute session, and 25 minutes for a half hour session.

If your child is being evaluated for services, we require full payment at the time of the assessment. The evaluation cost will depend on the amount of testing done and the time required for interpretation, scoring, consultation with additional professionals, etc.

We are not participating providers for any insurance company and therefore submission of invoices/claims is the responsibility of the patient's family.

Two week notice is required to alert your child's therapist to any unexpected termination of service. A fee equal to 2 weeks of service will be charged without this notice.

CANCELLATIONS:

In order to ensure your child gets the most out of his/her therapy program and that our therapist's available time is maximized, we must adhere to the following strict cancellation policy:

- **24-hour cancellation is preferred whenever possible; however, you must notify the office/therapist by 8:00am on the day of your appointment to avoid incurring a fee.** Please leave a message in your child's therapist's voice mailbox if someone is not personally available to take your call. The machine will record the day and time of your call. **Email cancellations are *not* acceptable unless made one week in advance of your scheduled appointment.**
- **All no-show appointments or appointments cancelled after 8:00am on the day of your child's scheduled session will be charged the full therapy fee.** This is necessary due to therapist's time spent planning and setting-up for that particular session and her/his inability to see another child during that time slot with late notice. **Makeup appointments are strongly encouraged; however, you will still be expected to pay for the missed session as well as the makeup session, unless made-up on the day of the missed appointment.** Cancellations due to an emergency will be reviewed on a case by case basis; this includes your child becoming sick while at school. A waiver of the late cancellation charge is not guaranteed.
- **Should you fail to cancel an appointment and/or not show up at your scheduled appointment three times during the course of your child's treatment, therapy will be terminated.** The same will hold true for frequent cancellations without rescheduling. You will be billed for any outstanding balance.
- **If you arrive late to an appointment, you are still responsible for the full session fee.**

- An 85% attendance rate is essential for your child's progress. Therefore, **during the 10 month school year, only 6 cancelled sessions are allowed for a once/week scheduled session or 12 for a child who is scheduled to receive treatment twice/week. After your cancellation limit has been reached, you will be charged for ½ of the treatment session rate for each subsequent cancellation, if you're unable to reschedule within 2 weeks of the cancelled appointment.**
- **Skill Builders will close on Labor Day, Thanksgiving Day, Christmas Day, New Year's Day, Memorial Day, and Independence Day.** Cancellations beyond the stated holidays will count toward your child's cancellation limit.
- Scheduling makeup appointments is strongly encouraged to ensure consistency in your child's treatment program. If scheduled within two weeks of an on-time cancel, the missed appointment will not count against your child's allowed missed sessions. This is, however, dependent on therapist's availability and therefore not guaranteed.
- **GROUP – This cancellation policy also applies to group therapy sessions, however, make-up appointments are not generally available. Frequent cancellations will result in a loss of your group treatment spot as one child's absence affects the entire group dynamic and progress.**

Any questions regarding this policy should be directed to Cari Syron, Clinic Owner and Director, at 703-941-7757 x101.

SICKNESS POLICY

In order to ensure the health of your child, the health of other children that we serve, and the health of our therapists, we request that parents/caregivers cancel therapy sessions for the following communicable illnesses as soon as symptoms appear:

- Fever of 100 degrees or over, within 24 hours of a visit
- Profusely runny nose due to viral or bacterial infection
- Active cough
- Influenza (flu)
- Strep Throat, unless child has been on antibiotics for four days
- Child or anyone in household with conjunctivitis (pink eye)
- Child or anyone in household with RSV (Respiratory syncytial virus)
- Vomiting or diarrhea within 24 hours of a visit
- Rotavirus
- Head lice
- Hand, foot, and mouth virus
- Ring worm
- Contagious rashes
- Any other contagious conditions
- Any illness preventing you or your child from participating in normal daily activities
- Any illness preventing your child from attending daycare or school

This policy applies to siblings and adults in the waiting area of our clinic, as well as the children we work with. If you are unsure if your child's condition is contagious, please consult your doctor before his/her session.

It is important to cancel for these conditions to protect the health of your child and the numerous other children we serve each day. Although some illnesses seem less severe than others, they can be detrimental to a medically fragile child.

If a therapist notices any of the above conditions, your child's session may be cancelled. This visit will be considered a late cancellation and will incur the full treatment fee.

Please help us to protect all of the children at Skill Builders by respecting the Sick Policy.

OT Case History Form

Person completing this form: ___________________________________ Date:________________

Relationship to child: ____

Insurance carrier: ___________________________________Referral

Source:__________________________

PATIENT INFORMATION

Child's name: _______________________________ Date of Birth:____________________
Address:____
Male / Female Age:________ Grade:_____________

FAMILY INFORMATION

Mother's name:_______________________________ Date of Birth:___________________
Occupation:___________________________ Work phone:__________________________
Address: ____

Father's name:________________________________ Date of Birth:___________________
Occupation:___________________________ Work Phone:__________________________
Address: ____

Sibling(s): ____________________________ Age:________________
____________________________ Age:________________
____________________________ Age:________________

Developmental and Medical History for Occupational Therapy

Briefly describe why you are pursuing an occupational therapy evaluation for your child:

____

Please circle the answers which best describe your child. Please add any remarks or comments that you feel may be helpful, including your child's strengths. This information is vital to our evaluation process—your observations give us details about day-to-day life, and so, help us to interpret our test findings with greater accuracy. Thank you for your time.

Before Birth:		**Remarks:**
1. Were there any illnesses, injuries, fainting spells, bleeding, anemia, operations, or any other medical difficulties?	YES NO	
2. Were there any drugs, medications, alcohol, or cigarettes used during pregnancy?	YES NO	
3. If adopted, provide the date and age when the child arrived at your home. Please specify any known details of care before adoption.	DATE__________ AGE___________	
Delivery: 1. Was the delivery premature?	YES NO	
2. Was medication given to induce labor or during labor? Please specify.	YES NO	
3. Was the labor abnormal? (prolonged, short) Please specify.	YES NO	
4. Was it an unusual delivery? (i.e. breech, Caesarean, forceps) Please specify.	YES NO	
5. What was the baby's gestational age (weeks) and birth weight?	AGE:_______weeks WEIGHT:_______lbs.	

Birth:

		Remarks:
1. Was the baby alert with normal muscle tone and color at birth?	YES NO	
2. Were there medical complications at birth affecting heart, lungs, kidneys, or digestive organs? Please explain.	YES NO	
3. Were there any congenital defects affecting the limbs, face, nerves, other body parts? Please explain.	YES NO	
4. Were there complications such as: cyanosis, jaundice, or limpness? Please specify.	YES NO	
5. Was there a need for oxygen, transfusions, IV, or tube feedings?	YES NO	
6. Did the baby spend extra time at the hospital or time in a special nursery?	YES NO	
7. Was the baby bottle or breast-fed? Please circle.	BOTTLE BREAST-FED	
8. Were there any feeding complications? Please specify.	YES NO	

Medical History Since Newborn Period:

			Remarks:
1. Are your child's immunizations up to date for the following:			
a. Measles, Mumps, & Rubella	YES	NO	
b. Chicken Pox	YES	NO	
c. Diphtheria, Pertussis, & Tetanus	YES	NO	
d. Polio	YES	NO	
e. Hepatitis B	YES	NO	
2. Describe any significant adverse reaction to vaccines.			

3. Circle any serious illnesses she/he has had and give dates & current status.	**Dates:**	**Remarks:**
a. Meningitis b. High Fevers c. Scarlet Fever d. Diabetes e. Seizures (dates, how often, type?) f. Respiratory, stomach, kidney, liver, or heart problems g. Any allergies (Please specify) h. Tuberculosis i. Polio j. Physical injuries k. Malnutrition l. Frequent ear infections/tubes m. Surgeries n. Others, please list:		
4. Has your child had vision and hearing exams? Circle & list dates, by whom, & results. a. Vision b. Hearing	**Dates:**	**Whom & Results:**
5. Is your child currently on medication? Please give names and reasons.	YES NO	**Names & Reasons:**
Developmental History At what ages did your child meet these motor milestones? Please note those that were skipped or not yet achieved.	**Age:**	**Comments/Clarifications:**
1. roll over both ways		
2. sit independently		
3. crawl on hands and knees		
4. cruise around furniture		
5. walk independently		
6. speak first word		
7. drink from a cup without a lid independently		
8. use a spoon independently		
9. demonstrate hand preference		Circle: Left handed/Right handed
10. put on shirt independently		
11. button independently		
12. dress independently		

	Age:	Comments/Clarifications:
13. ride a tricycle		
14. ride a bicycle without training wheels		
15. pump a swing		
16. learn to tie shoelaces		

Describe your child as an infant:

1. good, non-demanding	YES	NO
2. cried a lot, fussy, irritable	YES	NO
3. was alert	YES	NO
4. was active	YES	NO
5. was passive	YES	NO
6. liked being held	YES	NO
7. liked being rocked	YES	NO
8. was tense when held	YES	NO
9. was floppy when held	YES	NO
10. slept through the night easily	YES	NO
11. had irregular sleep patterns	YES	NO

Describe your child at present:

1. mostly quiet	YES	NO
2. talks constantly	YES	NO
3. overly active	YES	NO
4. tires easily	YES	NO
5. impulsive	YES	NO
6. restless	YES	NO
7. stubborn	YES	NO
8. resistant to changes	YES	NO
9. over-reacts	YES	NO
10. fights frequently	YES	NO
11. often happy	YES	NO
12. frequent temper tantrums	YES	NO
13. falls often	YES	NO
14. clumsy	YES	NO

Comments/Clarifications:

15. has difficulty separating from primary caregiver	YES	NO
16. wanders off without caution	YES	NO
17. has nervous habits or tics (Please specify)	YES	NO
Describe your child at present:		
18. wets bed	YES	NO
19. poor attention span	YES	NO
20. easily frustrated	YES	NO
21. has unusual fears (Describe)	YES	NO
22. rocks self during activities (Describe)	YES	NO
23. bangs head on purpose	YES	NO
24. has difficulty learning new tasks (i.e. bike riding, drawing/writing, throwing a ball, etc.)	YES	NO

SENSORY HISTORY

1. AUDITORY/HEARING/LANGUAGE.

Does your child:

a. respond negatively in response to unexpected or loud noises?(e.g. covering ears, running away, startling, or becoming distressed)	NO	YES
b. become bothered by household sounds such as a vacuum cleaner, hair dryer, dishwasher?	NO	YES
c. have difficulty paying attention when there are noises nearby?	NO	YES
d. tune into sounds that other people tend not to notice? (e.g. clocks ticking, refrigerators)	NO	YES
e. ask others not to talk, sing, or make noise?	NO	YES
f. enjoy singing and dancing to music?	NO	YES
g. seem confused about the direction from which sounds are coming?	NO	YES
h. appear to make noise for noise's sake?	NO	YES
i. appear not to hear some sounds?	NO	YES
j. appear hard of hearing?	NO	YES

Language skills

Comments/Clarifications:

k. have difficulty understanding phrases, directions, or stories other children her/his age can follow?	NO	YES
l. Did your child start to talk and then stop or lose a number of words?	NO	YES
m.Does your child sometimes repeat phrases from books or videos rather than composing his/her own sentences to play or make requests?	NO	YES
n. Does your child often "echo" phrases back to you?	NO	YES

2. VISUAL SYSTEM. Does your child:

a. maintain his/her visual focus on a task or object less than is expected?	NO	YES
b. rub his/her eyes, turn her/his head to the side, or squint when trying to read or look at objects closely?	NO	YES
c. have difficulty naming, discriminating, or matching colors, shapes or sizes?	NO	YES
d. show sensitivity to bright light, fluorescent lighting?	NO	YES

3. VESTIBULAR SYSTEM (of the inner ear, for balance and sense of motion). Does your child:

a. seem to twirl and spin more than others?	NO	YES
b. like to climb very high?	NO	YES
c. like fast carnival rides, merry go-rounds?	NO	YES
d. seem not to get dizzy when others usually do?	NO	YES
e. seem not as strong as peers?	NO	YES
f. frequently like to be inverted, tipped upside down, hang upside down, or enjoy doing lots of somersaults?	NO	YES
g. have trouble catching self when falling?	NO	YES
h. fall for no apparent reason?	NO	YES
i. have difficulty balancing?	NO	YES
j. seem fearful of movement as in going up and down stairs, moving on playground equipment?	NO	YES

Does your child:

Comments/Clarifications:

k. dislike being tossed in the air?	NO	YES	
l. dislike merry-go-rounds?	NO	YES	
m. dislike spinning & twirling?	NO	YES	
n. prefer to play in the house rather than at the playground with other children?	NO	YES	
o. get carsick?	NO	YES	
p. seem uncomfortable moving in space? (on open soccer field, crawling through small spaces, climbing, etc.)	NO	YES	
q. seem fearful of heights?	NO	YES	
r. resist balance activities?	NO	YES	
s. dislike swinging, being bounced on adult's lap as a young child?	NO	YES	

4. TACTILE SYSTEM/TOUCH. Does your child:

a. dislike going barefoot, insist on always wearing shoes &/or socks?	NO	YES	
b. pull away from light touch?	NO	YES	
c. seem excessively ticklish?	NO	YES	
d. startle or over-react to being touched unexpectedly?	NO	YES	
e. only accept touch from people he/she knows well?	NO	YES	
f. object to being touched by familiar people?	NO	YES	
g. stand or sit away from a group when with other children?	NO	YES	
h. avoid finger feeding him/herself messy foods?	NO	YES	
i. dislike many foods due to their textures (meats, crunchy snacks, soft smooth foods, mixed textures)? Please describe preferred textures.	NO	YES	
j. want to have hands clean at all times?	NO	YES	
k. avoid playing with messy things such as finger paint, sand, glue, glitter, or clay?	NO	YES	
l. show a dislike for typical grooming activities such as having teeth brushed, face washed, hair brushed, haircut, or nails cut? Please circle any that apply.	NO	YES	

Does your child:			Comments/Clarifications:
m. avoid certain textures of clothing such as fuzzy sweaters, woven shirts?	NO	YES	
n. prefer to wear long sleeves or pant legs regardless of weather?	NO	YES	
o. frequently pull down or push up long sleeves or pant legs?	NO	YES	
p. complain that bed sheets are too rough?	NO	YES	
q. prefer to touch rather than be touched?	NO	YES	
r. hurt others by pushing, bumping, pinching, and/or biting?	NO	YES	
s. isolate him/herself from other children?	NO	YES	
t. Struggle against being held or cuddled?	NO	YES	
u. Seem to lack the normal awareness of touch? (i.e. doesn't seem to notice food around mouth or face; clothes/socks are twisted).	NO	YES	
v. seem driven to touch things more than others of the same age?	NO	YES	
w. Crave touch from others?	NO	YES	
x. Feel pain MORE than others?	NO	YES	
y. Feel pain LESS than others?	NO	YES	

5. PROPRIOCEPTIVE SYSTEM (sensations from joints, muscles, and tendons).
Does your child:

a. grasp objects very tightly, write with heavy pressure, or slam doors?	NO	YES
b. grind her/his teeth?	NO	YES
c. seem driven to push, pull, drag, lift, or drop heavy objects?	NO	YES
d. seem driven to jump, crash into objects and people?	NO	YES
e. tend to break toys more than other children?	NO	YES
f. chew on nonfood objects?	NO	YES
g. use too much force when playing with others?	NO	YES

		Comments/Clarifications
h. crave hugging or rough play?	NO YES	
i. have difficulty sitting erect, prefer to lie on the floor than sit for extended periods, tire easily in one body position?	NO YES	
j. seem unsure how far to raise or lower body during movements such as sitting down or stepping over an object?	NO YES	
k. seem generally weak?	NO YES	
l. hold objects too loosely to use them effectively?	NO YES	
m. have poor motor coordination with small objects (e.g. pencils, buttons)?	NO YES	

6. GUSTATORY/OLFACTORY SYSTEM
(taste and smell) Does your child:

a. respond to odors that others don't notice?	NO YES	
b. have a history of resisting new flavors or textures?	NO YES	
c. like to taste non-food items such as glue or play dough?	NO YES	
d. explore objects by smell?	NO YES	
e. seem unaware of typical odors and scents?	NO YES	
f. react negatively to smells?	NO YES	
g. gag or complain of nausea when smelling odors that don't bother others?	NO YES	
h. chew on non-food objects?	NO YES	
i. have unusual cravings for: salt, sour, bitter, sweet? Circle all that apply.	NO YES	
j. act as though all food tastes the same?	NO YES	
k. have trouble with constipation?	NO YES	
l. have trouble learning urinary control?	NO YES	
m. have trouble learning bowel control?	NO YES	
n. Is your child toilet trained?	NO YES	
o. have a history of reflux? Is medication needed?	NO YES	

6. MOTOR DEVELOPMENT
Does your child have difficulty:

a. learning new large motor skills?	NO YES	

Comments/Clarifications

b. hopping on one foot?	NO	YES
c. jumping on two feet together?	NO	YES
d. skipping?	NO	YES
e. kicking a ball?	NO	YES
f. catching a ball?	NO	YES
g. learning how to use playground equipment?	NO	YES
h. cutting or pasting?	NO	YES
i. using small manipulative toys?	NO	YES
j. learning to hold a pencil or crayon in a 3 point position?	NO	YES
k. learning to write letters and numbers?	NO	YES

Does your child have difficulty:

l. moving fast enough to keep up with peers when m. playing in a group?	NO	YES
n. keeping her/his balance or feeling confident enough to try activities that demand good balance?	NO	YES
o. having enough strength and endurance to keep up with same aged peers?	NO	YES
p. avoiding injury during active play?	NO	YES

7. SOCIAL ADJUSTMENT

Does your child:

a. find it hard to make friends among his/her peers?	NO	YES
b. prefer the company of adults or older children?	NO	YES
c. prefer playing with younger children?	NO	YES
d. play with age-appropriate toys?	NO	YES

8. SCHOOL PERFORMANCE

Does your child:

a. need to prop his/her head with a hand while reading or writing at a desk?	NO	YES
b. seem confused over which hand or foot is left or right?	NO	YES

c. make reversals of letters or numbers when writing?	NO	YES
d. read words in reverse?	NO	YES
e. find PE or sports to be difficult or frustrating?	NO	YES
f. have any learning problems? Please specify.	NO	YES

What are your greatest concerns for your child relative to his/her development and occupational therapy?

What are your child's strengths?

Please comment on your child's school behavior.

What are your child's favorite activities/stories?

What activities or situations bring out your child's most mature behavior?

Does your child behave differently at home than in other settings? Please describe.

What else would you like your OT to know about your child?

Has your child had any of the following examinations? If so, please give the approximate date and the examining person's name and address:

	Date	By Whom	Address
Most recent physical examination			
Neurology			
Psychiatry			
Psychology			
Education			
Speech and Hearing			
Other special examinations			

Additional information that would help us to better understand your child:

DIRECTIONS TO SKILL BUILDERS

Annandale Office

7617 Little River Turnpike, Suite 310
703-941-7757

From 495, take exit for **236 East: Little River Turnpike**

(from the north – 2nd exit after Gallows Road, inside beltway)

(from the south – exit after Braddock Road)

Stay in right lane off the ramp (not right turning lane)

Go straight at stoplight at Heritage Drive

7617 is the first building on the right, immediately after Heritage stoplight.

Sun Trust Bank is on the 1st floor

From Alexandria, coming down 236 West:

One mile past Evergreen Lane

Go **Left at Stoplight at Heritage Drive** (last light before beltway)

Turn Left into parking area (first left available)

****Parking is available on sides or front of building, or on top floor of parking deck (located between 7617 and building next door)****

McLean Office

1481 Chain Bridge Road, Suite 102
703-750-2443

From 495 or 66, take 123 N towards McLean (123 is Dolley Madison Blvd.)

Right on Great Falls Street

Left on Chain Bridge Road

Pass Westmoreland and get into right lane

Go a bit, and look for McLean Professional Park on the right

1481 is in the 2nd row of office buildings/ #102 is in the center