



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

	<u>Page(s)</u>
Dear Parents	2
Speech and Language Services	3 – 4
Fee Information	5 – 6
 Release of Information and Receipt of Policies Form	7
General Office Policies	8
Payment and Cancellation Policies	9 – 10
Sickness Policy	11
 Speech-Language Case History Form	12 – 24
Directions to Skill Builders	25

 **Please fill out these forms and mail them to Cari Syron prior to your first session at Skill Builders.**

Thank you!



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

Dear Parents,

Thank you for your interest in the speech/language services available through Skill Builders, LLC. This packet specifically addresses the important questions regarding fees, therapy times, and locations of our offices for speech/language therapy. If you're interested in occupational therapy, please contact the OT scheduling coordinator, Beatrice Bruno, at (703) 750-2443, extension #110.

After reviewing the information in this packet, we request that you contact the office with any additional questions or to discuss scheduling an evaluation or therapy for your child. We also welcome families to call and schedule a visit to see our setting. Because of our full therapy schedule, return calls are usually made either in the middle or at the end of the day. Please feel free to leave a message regarding the best times to reach you. Once again, thank you for your interest, and we look forward to speaking with you soon!

Sincerely,

Cari Syron, MA CCC-SLP
Owner/Clinic Director



SPEECH LANGUAGE SERVICES

The speech and language pathologists at Skill Builders, LLC specialize in the evaluation and treatment of speech and language delays and disorders of the pediatric population (infants through adolescents).

Appropriate referrals include, but are not limited to:

Infants and preschoolers with any of the following -

Feeding difficulties secondary to in coordination of related musculature or abnormal tone of the oral facial musculature.

Delayed or disordered speech and/or language skills including but not limited to - articulation and/or language difficulties associated with recurrent middle ear infections, genetic disorders, hearing loss, motor speech disorders, developmental delay, autism, or of an unknown etiology.

Auditory or language processing concerns within the preschool classroom or busy environment.

Difficulty with peer relations.

Children through their teens with any of the following -

Suspect / identified language learning disabilities of varying etiologies.

Auditory processing difficulties.

Auditory attention disorders.

Pragmatic language disorders.

Persistent misarticulations.

Fluency difficulties.

Hearing impairments.

Orthodontic concerns related to tongue thrust / frontal tongue protrusion.

Oral Motor Dysfunction.

Atypical or delayed reading skill development.

Written Language difficulties.

Skill Builders

Speech Language and Occupational Therapy Services



SPEECH LANGUAGE SERVICES

Therapist qualifications:

All speech therapists have Master's Degrees in Speech Pathology, are licensed in Virginia and either hold or are eligible for the Certificate of Clinical Competence from the American Speech, Language, and Hearing Association. All Skill Builders therapists are required to maintain an exceptionally high level of continuing education credits within the area of Speech Pathology and other related fields.

Office location:

Our Annandale office is conveniently located 1/4 mile off of the Beltway on Little River Turnpike. From the Beltway take Little River Turnpike East toward Annandale. The 2nd right, after the 1st traffic light, is the entrance to the office building's rear parking garage. Parking is also available along the front and side of the building, and this office is wheelchair accessible.

Our McLean office is located at 1481 Chain Bridge Road, Suite 102. From the Beltway take the Chain Bridge exit towards McLean. Take a right on Great Falls St. and a left on Chain Bridge Road. The McLean Professional Park is about 1 mile down the road on your right. Parking is available in front of the office. This office requires descending 4 stairs and is therefore not easily wheelchair accessible.

Office setting:

Our Annandale office is child friendly with several styles of therapy rooms. Some children benefit most from a large room, with swings and a ball pit for sensory based therapy activities, others from an environment with limited distractions. The McLean office also offers a child friendly atmosphere, but in a smaller setting. Because of the greater number of treatment rooms, more availability for therapy is generally found in our Annandale office.

Other therapy services:

Occupational therapy services are also available within our McLean and Annandale offices. Co-treatment, in which speech and occupational therapies are provided within the same session, is available in both offices and is ideal for those children presenting with a combination of sensory integrative and language disorders.

On site therapy and/or consultation is provided at several preschools and private schools in the area. This allows your child's therapist to best address his/her needs in their educational environment.



FEE INFORMATION SHEET

(effective November 1, 2010)

Speech & Language Evaluation - \$500.00

This includes a comprehensive evaluation (up to 2 ½ hours of testing), parent conference, and a formal written report to document test results. Evaluations are scheduled in the office. Required additional testing is billed at the hourly rate of \$120.00. (For children B – 2 yrs, 11 mos., the fee for an evaluation is \$350.00). For fluency evaluations, the fee is \$400.00

Articulation / Oral Motor Evaluation Only - \$200.00 for children 3 years and older.

This includes evaluation of articulation and oral motor skills. A written report is provided. A parent conference is provided immediately following testing to discuss findings and recommendations.

Fast ForWord Evaluation - \$350.00

This evaluation includes pre testing for the Fast ForWord program only. Post testing is \$150.00. Pre-testing is selected to determine eligibility of this program and is not meant to provide extensive language diagnostics. Post testing is performed to quantify progress made from participation in the Fast ForWord program only.

Speech and Language Therapy

\$120.00 per hour – office	\$130.00 per hour – home/school*
\$90.00 per ¾ hour – office	\$100.00 per ¾ hour – home/school*
\$65.00 per ½ hour – office	\$70.00 per ½ hour – home/school*

*Home/School therapy is provided only as our overall caseload permits – rate is for those sessions within a 5 mile radius

**A 10% off sibling discount is available for 45 minute-1 hour individual, on-site, ST or OT sessions as well as for 1 hour social duo groups run by one therapist

Actual duration of a therapy session incorporates 5-15 minutes for parent conference and therapist documentation. Actual time with child will be less than scheduled session duration (i.e. a one hour session includes 45-50 minutes of direct time with the child and 10-15 minutes for conference, clean up, billing, etc.)

Therapy fees include periodic telephone consults with associated therapists and/or teachers to discuss the child's therapy goals and progress. One progress report is provided per six-month period without charge.

Speech and Occupational Therapy co-treatment is available using the above fees for Speech plus the additional fee for Occupational Therapy (in office only).

Consultation - \$120.00 per hour

Consultative services are available for those families who request periodic input regarding a child's speech and language development, school progress, use of augmentative communication systems, and for the development of appropriate home programs. Consultative services are also available at the child's school or daycare setting.

IEP Development - \$120.00 per hour

IEP development and planning services are available to families needing support through the IEP / special education maze. Therapists will also attend IEP meetings as requested and at the regular hourly rate of \$120/hour.

Additional Fees: Copies of superbills and treatment notes are provided at the end of each session for your records as well as to provide to your insurance company as needed. Additional copies of these items are billed at \$1.00 per copy.

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.



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: _____

AREA OF CONCERN

Please describe the speech, language, voice, fluency, feeding, or learning areas that you are concerned with:

When was the problem first noticed? _____

By whom was the problem first noticed? _____

Has your child received any previous help for the areas of concern? **YES / NO** (If yes, please list the type of help, dates of service, and the name of the professional or agency involved.)

- 1) _____
- 2) _____
- 3) _____
- 4) _____

Name of your child's pediatrician: _____

Address of the pediatrician: _____

FAMILY HISTORY

Are there any family members or relatives who have or have had speech, language, voice, hearing, reading or writing difficulties? **YES / NO** (If yes please provide additional information)

Is any language other than English spoken in the home? **YES / NO** (If yes, please list all languages that are spoken)

By whom is/are the languages other than English spoken and how frequently?

PREGNANCY AND BIRTH HISTORY

Please check all that apply

Type of Complication	1st Trimester	2nd Trimester	3rd Trimester
Infectious/communicable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fall	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Auto accident	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
X-Rays	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Surgeries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Miscarriages	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Overweight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spotting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Edema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toxemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Was the baby full term? _____ If not, how early/late? _____

What was the length of labor? _____ Induced? _____ Cesarean? _____

What type of anesthesia? _____ Were forceps used? _____

Baby's weight/length? _____

Were there any complications during delivery? **YES / NO** (If your answer is "yes" please provide further explanation)

Did the baby require oxygen? _____

Was he/she jaundiced? _____

Were there any complications immediately following the birth or during the first few weeks of life:

- | | | |
|---|---|---|
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Difficulty Sucking | <input type="checkbox"/> Difficulty Feeding |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Birth Defect | <input type="checkbox"/> Transfusions |
| <input type="checkbox"/> Extended Hospital Stay | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Rubella Herpes |
| <input type="checkbox"/> Syphilis | <input type="checkbox"/> Sepsis | <input type="checkbox"/> Other (Please Specify) |

Additional Comments:

DEVELOPMENTAL HISTORY

Please check all that apply to your child:

<u>Behavior</u>	<u>Yes</u>	<u>No</u>	<u>Approximate age the behavior started</u>	<u>Additional explanations</u>
Cried less than normal	<input type="checkbox"/>	<input type="checkbox"/>		
Smiled less than normal	<input type="checkbox"/>	<input type="checkbox"/>		
Unusual crying sound	<input type="checkbox"/>	<input type="checkbox"/>		
Distracted during breast feeding	<input type="checkbox"/>	<input type="checkbox"/>		
Yelled/screamed to attract attention	<input type="checkbox"/>	<input type="checkbox"/>		
Rocking or banging of head	<input type="checkbox"/>	<input type="checkbox"/>		
Generally indifferent to sound	<input type="checkbox"/>	<input type="checkbox"/>		
Difficulty sucking	<input type="checkbox"/>	<input type="checkbox"/>		
Difficulty chewing	<input type="checkbox"/>	<input type="checkbox"/>		
Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>		
Preferred foods	<input type="checkbox"/>	<input type="checkbox"/>		
Excessive drooling	<input type="checkbox"/>	<input type="checkbox"/>		
Other:	<input type="checkbox"/>	<input type="checkbox"/>		

At what age did the following occur? (Please give your closest time approximation)

Held head up	_____	Weaned from bottle	_____
Rolled over back to stomach	_____	Ate from spoon	_____
Sat unsupported	_____	Drank from an open cup	_____
Crawled	_____	Ate lumpy/chopped food	_____
Walked unassisted	_____	Ate meat/solids	_____

FEEDING BEHAVIORS

Has your child had any feeding difficulties?

- | | |
|--|---|
| <input type="checkbox"/> Sucking or nursing | <input type="checkbox"/> Difficulty chewing or swallowing meats |
| <input type="checkbox"/> Choking and / or gagging | <input type="checkbox"/> Excessive length of time to drink bottle |
| <input type="checkbox"/> Regurgitation of liquids or solids through the nose | |

Does your child choke while eating? **YES / NO** (If “yes”, on which foods?)

Is your child a picky eater? **YES / NO** (If “yes”, what foods does he / she prefer?)

Describe any feeding problems your baby experienced during the first 3 months of life.

Does your child drool more than other children his / her age? **YES / NO**

Did your child have difficulty gaining weight as an infant? **YES / NO**

At what age did the following occur?

<u>Expressive and Receptive milestones</u>	<u>Age</u>	<u>Additional info/explanation</u>
Respond to own name		
Followed simple directions		
Recognized names of familiar objects		
Pointed to eyes, nose, and mouth when named		
Babbled		
Said first word		
Had a vocabulary of 10 words		
Combined two-words		
Talked in short sentences		
Said full name		
Verbally related events/experiences		

At the present time:

Does your child follow directions correctly? **YES / NO** (If your answer is “no” please provide further explanation of what your child does in place of this behavior)

Does your child respond to questions appropriately? **YES / NO** (If your answer is “no” please provide further explanation of what your child does in place of this behavior)

Do you need to use gestures? **YES / NO** (If your answer is “yes” please provide further explanation of what your child does in place of this behavior)

Do you need to repeat? **YES / NO** (If your answer is "yes" please provide further explanation of what your child does in place of this behavior)

Do you need to speak in short sentences? **YES / NO** (If your answer is "yes" please provide further explanation of what your child does in place of this behavior)

How does your child communicate his/her wants and needs?

How much of your child's speech do you understand?

- 10% 25% 50% 75% 100%

How much of your child's speech do unfamiliar listeners understand?

- 10% 25% 50% 75% 100%

Does a parent need to interpret for others? **YES / NO** (If your answer is "yes" please provide further explanation)

Does your child grope for words or use the wrong word? **YES / NO** (If your answer is "yes" please provide further explanation of his/her behavior)

Does your child repeat sounds or words previously heard? **YES / NO** (If your answer is "yes" please provide further explanation of his/her behavior)

Does your child's voice have a nasal or harsh quality? **YES / NO** (If your answer is "yes" please provide further explanation of his/her behavior)

Does your child seem to have adequate hearing? **YES / NO** (If your answer is "no" please provide further explanation of his/her behavior)

Has your child's hearing ever been tested? **YES / NO** If so where? _____

When? _____ Results of test: _____

MEDICAL HISTORY

<input type="checkbox"/> Adenoidectomy	Age _____	<input type="checkbox"/> High fevers	Age _____
<input type="checkbox"/> Allergies	_____	<input type="checkbox"/> Influenza	_____
<input type="checkbox"/> Asthma	_____	<input type="checkbox"/> Measles	_____
<input type="checkbox"/> Blood disease	_____	<input type="checkbox"/> Meningitis	_____
<input type="checkbox"/> Chicken pox	_____	<input type="checkbox"/> Mumps	_____
<input type="checkbox"/> Seizures	_____	<input type="checkbox"/> Muscle disorder	_____
<input type="checkbox"/> Croup	_____	<input type="checkbox"/> Nerve disorder	_____
<input type="checkbox"/> Dental problems	_____	<input type="checkbox"/> Orthodontia	_____
<input type="checkbox"/> Diphtheria	_____	<input type="checkbox"/> Pneumonia	_____
<input type="checkbox"/> Earaches	_____	<input type="checkbox"/> Polio	_____
<input type="checkbox"/> Ear infections	_____	<input type="checkbox"/> Rheumatic fever	_____
<input type="checkbox"/> Encephalitis	_____	<input type="checkbox"/> Scarlet fever	_____
<input type="checkbox"/> Eye problems	_____	<input type="checkbox"/> Tonsillectomy	_____
<input type="checkbox"/> Headaches	_____	<input type="checkbox"/> Tonsillitis	_____
<input type="checkbox"/> Head injury	_____	<input type="checkbox"/> Tuberculosis	_____
<input type="checkbox"/> Heart Problems	_____	<input type="checkbox"/> Whooping cough	_____

Please describe any other serious illnesses, injuries or physical problems not mentioned above:

Does your child have any allergies? **YES / NO** (If your answer is "yes" please list all allergies)

Does your child take any medications? **YES / NO** (If your answer is "yes" please list all medications)

Has your child ever been hospitalized? **YES / NO** (If your answer is "yes" please provide further explanation)

SOCIAL / EMOTIONAL DEVELOPMENT

Please check all behaviors that you feel best describe your child:

- | | |
|---|---|
| <input type="checkbox"/> Overly active | <input type="checkbox"/> Defiant |
| <input type="checkbox"/> Overly quiet | <input type="checkbox"/> Easily controlled/passive |
| <input type="checkbox"/> Destructive | <input type="checkbox"/> Very shy |
| <input type="checkbox"/> Perfectionist | <input type="checkbox"/> Friendly |
| <input type="checkbox"/> Outgoing | <input type="checkbox"/> Plays well with other children |
| <input type="checkbox"/> Prefers older children | <input type="checkbox"/> Prefers younger children |
| <input type="checkbox"/> Difficulty separating from parents | <input type="checkbox"/> Anxious |
| <input type="checkbox"/> Happy | <input type="checkbox"/> Stubborn |

SOCIAL BEHAVIOR

Which of the following describes the type of play your child likes to engage in most often?

- | | | |
|--|--|---|
| <input type="checkbox"/> Putting toys in mouth | <input type="checkbox"/> Shaking toys | <input type="checkbox"/> Banging toys together |
| <input type="checkbox"/> Uses one object for another | <input type="checkbox"/> Throwing toys | <input type="checkbox"/> Pushing / Pulling toys |
| <input type="checkbox"/> Does role playing | <input type="checkbox"/> Games with rules | <input type="checkbox"/> Acts out familiar routines |
| <input type="checkbox"/> Rough & tumble play | <input type="checkbox"/> Make believe play | <input type="checkbox"/> Appropriate use of objects |

What is the average length of time your child can stay playing at one activity? _____

What activities seem to hold your child's attention for the shortest period of time?

What activities seem to hold your child's attention for the longest period of time?

How does your child relate to you? _____

To your spouse? _____

To other children? _____

What is/are your child's preferred play activities? _____

Does your child avoid any play activities? **YES / NO** (If your answer is "yes" please provide further explanation of his/her behavior)

Is your child toilet trained? **YES / NO**

EDUCATIONAL HISTORY

Name of school your child is attending? _____

Name of his/her present teacher(s)? _____

Grade: _____ Full time? **YES / NO** (If your answer is "no" please list any other school(s) or daycare he/she attends, as well as how often)

What are your child's best subjects? _____

Worst subjects? _____

Does your child receive services from school? **YES / NO** (If yes please provide how often and by whom)

In scheduling your child's evaluation or therapy, is there any need for handicapped accessibility?

Other pertinent information or comments:

*Please provide copies of any pertinent assessments, reports, and/or records prior to your child's first appointment. **THANK YOU!**

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