Sharon M Parkinson, Psy.D., PL

Health and Developmental History

Please complete the following information regarding your history (or your child's if this is completed by a parent) and return to us at the time of the evaluation. Please be as specific as possible. Please provide copies of previous evaluations or medical reports.

Name: _____ DOB: _____
Education Level: _____ Handedness: Right Left Ambidextrous
Marital Status: M S W D Number of Children: _____

Reason sought services (what are your goals)_____
_____
_____

BIRTH AND DEVELOPMENT:

Childbirth: Natural C-Section
Were there any complications during birth? Yes No If yes, please explain: _____
_____
_____

Were there any delays in reaching developmental milestones (i.e., speech, fine or gross motor skills)?
_____
_____

Age said first words: _____ Age said first sentences: _____ Age was potty-trained: _____
Age started crawling: _____ Age started walking: _____

EDUCATION:

Please list any schools that you have attended for grades K through current:

School Name	City/State	Grades/Years

Grades (GPA) in Elementary School: _____ Grades (GPA) in High School: _____
Did you graduate? Yes No Standard Diploma, Option 1, Option 2 (circle)

What was/is your major in college? _____ GPA: _____

Were you ever diagnosed with a specific learning disability? Yes No If Yes, Please explain:
_____
_____

Were you ever diagnosed with ADHD? Yes No When? _____
Was treatment with a stimulant tried? Yes No If so, when and for how long? _____

Did you have an IEP? Yes No If so, when was this established and what accommodations were provided? _____
_____
_____

What were your favorite subjects in school? _____
What classes did you struggle in? _____

What were your scores on FCATS? _____ Accommodations? Yes No
What were your scores on ACT or SAT? _____ Accommodations? Yes No
Other standardized testing: _____

Have you worked? Yes No Current Job Title: _____

Are you (please circle one): Working Full-time Working Part-time Retired

If so, tell us about your previous jobs (i.e., when you started, how many hours per week, what were your responsibilities?)

_____
_____
_____

Are you (or have you been) involved in extra-curricular activities?

_____
_____
_____

Personal and Family Medical History

Family History

	Illnesses	Living	Deceased	Age	Hx of Dementia?
Father:	_____	( )	( )	_____	Yes No
	_____				
	_____				
Mother:	_____	( )	( )	_____	Yes No
	_____				
	_____				
Siblings:	_____	( )	( )	_____	Yes No
	_____	( )	( )	_____	Yes No
	_____	( )	( )	_____	Yes No

Allergies: _____ Medications: _____
_____ _____
_____ _____

Surgeries/Illnessess: _____ Date: _____
_____ Date: _____
_____ Date: _____

Health Concerns:

Personal	Family		Personal	Family		Personal	Family	
( )	( )	Diabetes	( )	( )	Alzheimer's	( )	( )	Schizophrenia
( )	( )	Hypertension	( )	( )	Parkinson's	( )	( )	ADHD
( )	( )	High Cholesterol	( )	( )	Brain Injury	( )	( )	Alcohol Abuse
( )	( )	Thyroid Problems	( )	( )	Depression	( )	( )	Rx Drug Abuse
( )	( )	Heart Disease	( )	( )	Anxiety	( )	( )	Illicit Drug Abuse
( )	( )	Cancer	( )	( )	Bipolar Disorder	( )	( )	Cigarette Smoking
( )	( )	Stroke	( )	( )	Panic Disorder	( )	( )	Learning Disability

Substance use: Illicit or prescription drug abuse History Current
Alcohol History Current Approximate use: _____
Tobacco/Nicotine History Current Approximate use: _____

Current Symptoms/Problems in your own words:

_____
_____
_____
_____

Changes in Memory or Cognitive? Yes No Please explain:

_____
_____
_____

Was the symptom onset sudden or gradual?

Any problems coming up with words you want to say or expressive language problems? Yes No

Problems with balance? Yes No

Problems with urinary incontinence? Yes No

Have you ever been, or are you now, treated for Depression? Yes No
Have you ever been, or are you now, treated for Anxiety? Yes No
Have you ever been, or are you now, treated for Bipolar Disorder? Yes No
Have you ever been, or are you now, treated for any other psychiatric illness? Yes No
Please explain:

_____
_____
_____

THANK YOU FOR YOUR TIME IN COMPLETING THIS FORM.