

Gagandeep Singh, M.D., LLC – Personal History Form

Please answer these questions as pertaining to the patient – parents/caregivers may assist minors.

Please briefly describe the recent concerns which have led to your seeking this evaluation/treatment.

What are your three biggest stressors at this time?

1. _____
2. _____
3. _____

Psychiatric History

Do you have a history of psychiatric issues, treatment, and/or hospitalizations? Yes No

If so, please complete the following:

Diagnosis	Dates Treated	By Whom	Where (Hospital/Office)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you taken psychiatric medications in the past or currently? If so, please list them here along with approximate dates, as well as whether they were helpful.

If you have an extensive history (more than 4 or 5 medications in the past), please use the Medication History Form which is also available on the website.

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Are you currently receiving professional counseling or any kind of psychotherapy? Yes No

If yes, by whom? _____ Phone: _____

Suicide Risk Assessment

Have you ever had feelings so bad that you have had thoughts that you didn't want to go on, or that you might want to kill yourself? Yes No

IF YES, please answer the following. If NO, please skip to the next section (Brief Screening Questions).

Is this unhappy feeling so strong you ever wish you were dead? Yes No

How often have you had these thoughts? _____

Has anything happened recently to make you feel like this? _____

On a scale of 1 to 10, how strong is your desire to kill yourself (10 = strongest desire)? _____

What would it take to move you one point down the scale? _____

Have you ever thought about how you would kill yourself? _____

Is the method you would use readily available? _____

Have you planned a time for this? _____

Have you ever tried to kill or harm yourself before? _____

Did things change as a result of these attempts? _____

Is there anything that would stop you from killing yourself? _____

If you could look into the future, what do you feel you could look forward to? _____

Brief Screening Questions

Are you having difficulty with sleep (hard to fall asleep or stay asleep, early awakening)? Yes No

Has your appetite been significantly greater or less than usual? Yes No

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Are you bothered by hearing voices/sounds or seeing things others cannot see? Yes No

Do you have difficulty with focusing or following through on tasks? Yes No

Family Psychiatric History:

Please circle, if applicable, any psychiatric issues you know of in your family:

Depression	Anxiety	Bipolar disorder	Schizophrenia	PTSD
Suicide Attempts	ADHD	Anger/Violence	Alcohol/Substance Abuse	

If applicable, please list which relatives have struggled with which of the above issues.

Has any family member been treated with a psychiatric medication? Yes No

If yes, what medications and how effective were they? _____

Medical Information:

Allergies _____

Current prescription medications for medical issues and how often you take them (if none, write 'none'):

Current over-the-counter medications or supplements: _____

Current medical problems: _____

Past medical problems, hospitalizations or surgeries: _____

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Do you have any concerns about your health you would like to discuss with me? Yes No

Please circle all applicable medical/health issues you have had in the past or currently:

Thyroid Disease	Heart Disease	High Cholesterol	High Blood Pressure
Liver Disease	Kidney Disease	Head Trauma	Asthma/Breathing Problems
Seizures	Diabetes	Cancer	Stomach/Intestinal Problems
Chronic Fatigue	Fibromyalgia	Chronic Pain	Anemia
Depression	Bipolar Disorder	Psychosis	Anxiety/Panic Attacks

Is there a family history of anything listed above? Please explain: _____

Name of your primary health care provider: _____

Phone: _____ Address _____

Date and place of last physical exam: _____

Have you ever had an EKG? Yes No Date _____

Have you ever had routine blood-work? Yes No Date _____

For women only:

Date of last menstrual period _____ Birth control method _____

Are you currently pregnant or do you think you might be pregnant? Yes No

Are you planning to get pregnant in the near future? Yes No

How many times have you been pregnant? _____

How many live births have you had? _____

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Developmental History:

When your mother was pregnant with you, were there any complications with the pregnancy or birth?

Did you meet all developmental milestones on time (walking, talking, toilet training, etc.)? Yes No

If NO, please explain: _____

Substance Use:

Have you ever been treated for alcohol or drug use or abuse? Yes No

If yes, for which substances? _____

If yes, where were you treated and when? _____

How many alcoholic drinks do you consume each week? _____

In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day?

Cigarette use: Currently? Yes No In the past? Yes No

When did you quit? _____

How many per day on average? _____

For how many years? _____

Pipes, cigars, or chewing tobacco: Now? Yes No In the past? Yes No

What kind? _____

How often per day on average? _____

For how many years? _____

Have you used any street drugs in the past 3 months? Yes No

If yes, which ones? _____

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Please circle, if applicable, the names of any of the following substances that you have tried:

Marijuana	Cocaine/Crack	Heroin	Opiates/Painkillers	“Speed”
Stimulants	LSD/Hallucinogens	Alcohol	Inhalants	Ecstasy

If applicable, please list durations/dates for the use each substance: _____

Have you ever felt you should cut down on your drinking or drug use? Yes No

Have people annoyed you by criticizing your drinking or drug use? Yes No

Have you ever felt bad or guilty about your drinking or drug use? Yes No

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? Yes No

Social History:

Family Background and Childhood History:

Were you adopted? Yes No Where were you raised? _____

Did you grow up with both parents in the home? Yes No

If NO, please describe list your primary caretaker(s): _____

Did your parents divorce? Yes No If so, how old were you when they divorced? _____

Please list your brothers and sisters and their ages: _____

What was your father’s occupation? _____

Your mother’s occupation? _____

Describe your father and your relationship with him: _____

Describe your mother and your relationship with her: _____

How old were you when you left home? _____

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Where you ever physically or sexually abused? _____

If so, please explain what happened and at what age(s): _____

Marital/Relationship History:

Are you currently: Married Divorced Single Widowed Non-married committed

For how long? _____

What is your significant other's occupation? _____

Describe your relationship with your spouse or significant other: _____

Have you had any prior marriages? Yes No If so, how many? _____

For how long? _____

Do you have children? Yes No Ages: _____

Describe your relationship with your children: _____

List everyone who currently lives at home: _____

Are you currently dating, sexually active, or in a relationship(s)? Yes No

You would identify your sexual orientation as:

Straight/Heterosexual	Lesbian/Gay/Homosexual	Bisexual	Transsexual
Unsure/Questioning	Asexual	Other	Prefer not to answer

Do you have concerns related to your sexual orientation? Yes No

Educational History:

Did you attend college? Yes No If YES, where? _____

What was your major? _____

What is your highest educational level or degree attained? _____

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Occupational History:

Are you currently: Working Not Working

What is your occupation? _____

Where do you work? _____

How long in present position? _____

Legal History:

Have you ever been arrested? Yes No If YES, please explain: _____

Do you have any pending legal problems? Yes No If YES, please explain: _____

Spiritual Assessment:

Do you belong to a particular religion or spiritual group? Yes No

If yes, which religion or group? _____

Also, if yes, what is the level of your involvement? _____

Do you find your involvement helpful during this illness, or does the involvement make things more difficult or stressful for you? More Helpful More Difficult/Stressful

If you do not belong to a particular group, do you have any particular religious, spiritual beliefs or a philosophy of life that are particularly important to you? _____

Do your beliefs or philosophy of life affect how you to think or feel a about your illness? Yes No

If yes, how so? _____

As you face this illness, what activities do you use to help you cope, feel better, and heal? _____

What would you like your health care team and me, as your provider, to know about your spiritual needs as we care for you during this illness? _____
