PROMISE COMMUNITY HEALTH CENTER
• mental health •

33 4th Street NW, Sioux Center, IA 51250 | 712-722-1700 | care@promisechc.org | promisehc.org

Dear New Patient:

We welcome you to the practice of Emily Leinen, PMHNP. We appreciate the confidence you place in us as one of your health care providers, and thank you for choosing Promise.

We have some important reminders to inform you of so you can have an excellent experience while visiting our office. You are very important to us, and each appointment is valuable.

- We ask that you arrive 20 minutes before your scheduled appointment.
- As a Psych NP, Emily is considered a specialty practice. While billing will be handled the same, your copay or deductible may be a little higher.
- If you need to cancel or reschedule your appointment, please call us at 712-722-1700 as soon as possible.
- PMHNP office hours are Monday 8:00 am-5:00 pm and Tuesday through Friday 8:00 am-4:00 pm.
- Refills will be completed during office hours only.
- Please park in the parking lot across the street from Promise.

Enclosed you will find new patient paperwork. Please return completed paperwork to our office via mail, email, or by dropping it off at our office. Once we have received your completed paperwork, the nurse will reach out to you to schedule an appointment.

Email: medicalrecords@promisechc.org
Mail: 33 4th Street NW
Attn: Medical Records
Sioux Center, IA 51250

You will be receiving a reminder call or text from our automated service prior to your appointment. If you have any questions, please feel free to call our office at 712-722-1700. We look forward to meeting you.

Emily Leinen, PMHNP

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NEW PATIENT INFORMATION FORM

Patient Name:_____ DOB: ___/___/___ Date: ___/___/___

Reason for visit: _____

_____

Do you have a legal guardian? YES NO Name of guardian: _____

Referring person/provider: _____ Primary provider: _____

Pharmacy: _____

Circle any symptoms below that you are currently having (circle all that apply):

Anxiety	Depression	Mood problems	Irritability/anger	Suicidal thoughts	Sleep problems
Seeing things	Hearing things	Impulsiveness	Substance abuse	Concentration problems	Memory problems

Other symptoms of concern: _____

Allergies to medications? YES NO

Current Medications:

Name of medication:	Dose:	Number of times taken daily:

Past Psychiatric Medications:

Name of medication:	Dose:	Approx dates started & stopped:	Reason discontinued/reactions or intolerances:
		-	
		-	
		-	
		-	
		-	
		-	
		-	

PHQ 2: Over the last 2 weeks, how often have you been bothered by the following problems? (circle an answer for each)

Little interest or pleasure in doing things:	Not at all	Several days (+1)	More than half the days (+2)	Nearly every day (+3)
Feeling down, depressed or hopeless:	Not at all	Several days (+1)	More than half the days (+2)	Nearly every day (+3)

Problems at home/work/school/socially because of symptoms: (please score 0-10, with 0 being none)

Problems at work/school: _____/ 10 Problems socially: _____/ 10

Problems with family life/home responsibilities: _____/ 10

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SOCIAL HISTORY

Patient Name: _____

Growing Up Place of birth: _____ Place you grew up: _____

Were your parents: Married Divorced Single Other: _____

Do they remain married: YES NO Who raised you? _____

Step parents: YES NO _____ Other guardian caretaker: _____

Siblings: YES NO Number of brothers: _____ Number of sisters: _____

Step-siblings: YES NO Number of step-brothers: _____ Number of step-sisters: _____

Others you were raised with: YES NO _____

Life Growing Up (circle all that apply):

Safe Happy Content Good

Unsafe Unhappy Not content Bad Bullied

Other: _____

Current Living Situation Place you live now: _____ Others that live in the home: _____

Current marital status: Single Married Partner Other: _____

Previous marriages: YES NO

Do you currently feel? (circle all that apply):

Safe Happy Content Good

Unsafe Unhappy Not content Bad Bullied

Other: _____

Children YES NO Number of sons: _____ Number of daughters: _____

Step-children: YES NO Number of step-sons: _____ Number of step-daughters: _____

Provide details if desired: _____

Support System (who provides you with emotional support) _____

Education

Highest grade? _____ Did you graduate? YES NO From: _____ GED? YES NO

College: YES NO Did you graduate? YES NO Major/degree: _____

Learning disabilities/special ed: _____

Work History (what types of jobs have you had and/or do you have) _____

Military history? YES NO Branch? _____ Years served? _____

Legal Problems or Charges YES NO Current legal charges: _____

Past: _____ Probation/parole: _____

History of violence: _____

Substance Abuse History

Substance type	First age of use	Frequency of use when using	Typical amount used	Last use
Alcohol				
Marijuana				
Cocaine/crack/meth				
Hallucinogens				
Heroin/opiates				
Prescription drugs				
Caffeine use				
Nicotine (circle type) Cigarettes Cigars Pipe Chew				
Other (bath salts/K2):				
Drug of choice:				
History of alcohol withdrawal (seizures-shakes-tremors-hallucinations):				

Patient Name: _____

Treatment History

Drug/alcohol treatment	No	Yes	Dates	Provider/treatment facility

Treatment: AA/NA Outpatient IOP (Short or long) term residential

MEDICAL HISTORY

Current medical provider: _____

Current health concerns or diagnoses: _____

FEMALES ONLY Last menstrual period: ___/___/___ Birth control method: _____

Premenstrual symptoms: _____

Other symptoms (hot flashes, etc): _____

Only if pregnant or planning on becoming pregnant

OB doctor: _____ Prenatal classes: _____ Breast Bottle

Number of pregnancies: _____ Number of children: _____

Hand dominance: Left Right

Surgical History (check those for which you have a current or past history of):

	Adenoidectomy		Gallbladder		Knee replacement		Tonsillectomy
	Appendectomy		Gastric bypass		Right Left		Tubal ligation
	Colectomy		Hernia repair		Liver biopsy		Heart surgery/CABG
	Colonoscopy		Hysterectomy		Sinus surgery		Heart stent/valve
	Colostomy		Hip replacement		Small bowel resection		Pacemaker
	C-section		Right Left				Defibrillator

Other surgical procedures: _____

Medical Review of Systems (check those for which you have a current or past history of):

	Alcohol dependence		**Gastrointestinal/colorectal**		**Musculoskeletal**
	Breast problems		> Cancer		> Broken bones
	Cancer		> Celiac disease		> Muscle damage/tears
	> Type _____		> Constipation		> Osteoarthritis
	Cardiovascular/heart		> Crohn's disease/ulcerative colitis		> Use wheelchair/walker/cane
	> High blood pressure/hypertension		> Diarrhea		**Respiratory**
	Head/brain		> GERD/Reflux		> Asthma
	> Concussion		> Irritable bowel disease		> COPD
	> Traumatic brain injury		> Peptic ulcer		> Emphysema
	> Seizures		**Endocrine**		> History of bronchitis
	> Stroke/cerebral vascular accident		> Thyroid Problems		> History of pneumonia
	> TIA/transient ischemic attack		> Diabetes		**Urinary problems**
	High cholesterol		> PCOS (poly cystic ovarian syndrome)		**Vascular problems**
	Liver disease		**Autoimmune**		> Gastric or esophageal varices
	> Cirrhosis		> Rheumatoid arthritis		> Blood clots
	> Hepatitis A B C		> Lupus		**Weakness, general**
	Gallbladder problems		**Pancreatitis**		**Other** _____

Constitutional YES	Eyes YES	GI YES	Endo/heme/allergies YES

Patient Name: _____

Medical Review of Systems (check those for which you have a current or past history of):

	Appetite changes		Blurred vision		Abdominal bloating		Adenopathy
	Fever		Double vision		Heartburn		Easy bruising/bleeding
	Chills		Photophobia		Anorexia		Environmental allergies
	Weight gain		Eye pain		Bowel changes		Cold intolerance
	Weight loss		Eye discharge		Bowel incontinence		Heat intolerance
	Malaise/fatigue		Eye redness		Nausea		Polydipsia (excess thirst)
	Diaphoresis/sweating		Vision loss left		Vomiting		Polyphagia (excess hunger)
	Night sweats		Vision loss right		Hematemesis (throwing up blood)		Polyuria (excess urination)
			Visual disturbance		Abdominal pain		
			Halo vision		Diarrhea		
	Skin				Constipation		**Neurological**
	Changes in nail beds				Hemorrhoids		Aphonia (loss of speech)
	Discoloration		**Cardiovascular**		Jaundice		Brief paralysis
	Dryness		Chest pain		Dysphagia		Concentration problems
	Flushing		Cyanosis		Excessive appetite		Coordination problems
	Rash		Shortness of breath on exertion		Bloody or dark tarry stools		Daytime sleepiness
	Poor wound healing		Irregular heartbeats				Dizziness
	Itching		Palpitations				Light-headedness
	Skin cancer		Orthopnea		**GU**		Loss of balance
	Suspicious skin lesion		Claudication - pain in legs		Bladder incontinence		Numbness
	Unusual hair growth		Near syncope		Decreased libido		Paresthesia
			Syncope/fainting		Painful urination (dysuria)		Tingling
			Leg swelling		Genital sore		Tremor
	Hent		PND(paroxysmal nocturnal dyspnea)		Urgency		Sensory changes
	Headache				Hesitancy		Speech changes
	Hearing loss				Incomplete empyting		Focal weakness
	Hoarseness		**Respiratory**		Frequency		General weakness
	Tinnitus (ear ringing)		Cough		Nighttime urination		Seizures
	Ear pain		Hemoptysis		Hematuria - blood in urine		Loss of consciousness
	Ear discharge		Sputum production		Flank pain		Vertigo
	Nose bleeds		Shortness of breath		Menorrhagia		
	Congestion		Sleep disturbance		Missed periods		
	Strider		Snoring		Non-menstrual bleeding		**Psychiatric**
	Sore throat		Wheezing		Pelvic pain		Altered mental status
							Depression
							Suicidal ideas
	Other Concerns:				**Musculoskeletal**		Substance abuse
					Arthritis		Thoughts of violence
					Myalgia		Hallucinations
					Neck pain		Hypervigilance
					Back pain		Anxiety/nervousness
					Joint pain		Insomnia
					Joint swelling		Memory loss
					Muscle cramps		
					Muscle weakness		
					Stiffness		
					Falls		
					Gout		

Center for Epidemiologic Studies Depression Scale (CES-D), NIMH

Below is a list of the ways you might have felt or behaved. Please tell me how often you have felt this way during the past week.

	During the Past Week			
	Rarely or none of the time (less than 1 day)	Some or a little of the time (1-2 days)	Occasionally or a moderate amount of time (3-4 days)	Most or all of the time (5-7 days)
1. I was bothered by things that usually don't bother me.	☐	☐	☐	☐
2. I did not feel like eating; my appetite was poor.	☐	☐	☐	☐
3. I felt that I could not shake off the blues even with help from my family or friends.	☐	☐	☐	☐
4. I felt I was just as good as other people.	☐	☐	☐	☐
5. I had trouble keeping my mind on what I was doing.	☐	☐	☐	☐
6. I felt depressed.	☐	☐	☐	☐
7. I felt that everything I did was an effort.	☐	☐	☐	☐
8. I felt hopeful about the future.	☐	☐	☐	☐
9. I thought my life had been a failure.	☐	☐	☐	☐
10. I felt fearful.	☐	☐	☐	☐
11. My sleep was restless.	☐	☐	☐	☐
12. I was happy.	☐	☐	☐	☐
13. I talked less than usual.	☐	☐	☐	☐
14. I felt lonely.	☐	☐	☐	☐
15. People were unfriendly.	☐	☐	☐	☐
16. I enjoyed life.	☐	☐	☐	☐
17. I had crying spells.	☐	☐	☐	☐
18. I felt sad.	☐	☐	☐	☐
19. I felt that people dislike me.	☐	☐	☐	☐
20. I could not get "going."	☐	☐	☐	☐

SCORING: zero for answers in the first column, 1 for answers in the second column, 2 for answers in the third column, 3 for answers in the fourth column. The scoring of positive items is reversed. Possible range of scores is zero to 60, with the higher scores indicating the presence of more symptomatology.

Screen for Child Anxiety Related Disorders (SCARED)

Child Version - Page 1 of 2 (To be filled out by the CHILD)

Name: _____ **Date:** _____

Directions:
Below is a list of sentences that describe how people feel. Read each phrase and decide if it is "Not True or Hardly Ever True" or "Somewhat True or Sometimes True" or "Very True or Often True" for you. Then for each sentence, fill in one circle that corresponds to the response that seems to describe you for the last 3 months.

		0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True
1.	When I feel frightened, it is hard for me to breathe	o	o	o
2.	I get headaches when I am at school	o	o	o
3.	I don't like to be with people I don't know well	o	o	o
4.	I get scared if I sleep away from home	o	o	o
5.	I worry about other people liking me	o	o	o
6.	When I get frightened, I feel like passing out	o	o	o
7.	I am nervous	o	o	o
8.	I follow my mother or father wherever they go	o	o	o
9.	People tell me that I look nervous	o	o	o
10.	I feel nervous with people I don't know well	o	o	o
11.	My I get stomachaches at school	o	o	o
12.	When I get frightened, I feel like I am going crazy	o	o	o
13.	I worry about sleeping alone	o	o	o
14.	I worry about being as good as other kids	o	o	o
15.	When I get frightened, I feel like things are not real	o	o	o
16.	I have nightmares about something bad happening to my parents	o	o	o
17.	I worry about going to school	o	o	o
18.	When I get frightened, my heart beats fast	o	o	o
19.	I get shaky	o	o	o
20.	I have nightmares about something bad happening to me	o	o	o

Screen for Child Anxiety Related Disorders (SCARED)

Child Version - Page 2 of 2 (To be filled out by the CHILD)

		0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True
21.	I worry about things working out for me	o	o	o
22.	When I get frightened, I sweat a lot	o	o	o
23.	I am a worrier	o	o	o
24.	I get really frightened for no reason at all	o	o	o
25.	I am afraid to be alone in the house	o	o	o
26.	It is hard for me to talk with people I don't know well	o	o	o
27.	When I get frightened, I feel like I am choking	o	o	o
28.	People tell me that I worry too much	o	o	o
29.	I don't like to be away from my family	o	o	o
30.	I am afraid of having anxiety (or panic) attacks	o	o	o
31.	I worry that something bad might happen to my parents	o	o	o
32.	I feel shy with people I don't know well	o	o	o
33.	I worry about what is going to happen in the future	o	o	o
34.	When I get frightened, I feel like throwing up	o	o	o
35.	I worry about how well I do things	o	o	o
36.	I am scared to go to school	o	o	o
37.	I worry about things that have already happened	o	o	o
38.	When I get frightened, I feel dizzy	o	o	o
39.	I feel nervous when I am with other children or adults and I have to do something while they watch me (for example: read aloud, speak, play a game, play a sport)	o	o	o
40.	I feel nervous when I am going to parties, dances, or any place where there will be people that I don't know well	o	o	o
41.	I am shy	o	o	o

**For children ages 8 to 11, it is recommended that the clinician explain all questions, or have the child answer the questionnaire sitting with an adult in case they have any questions.*

Developed by Boris Birmaher, MD, Suneeta Khetarpal, MD, Marlane Cully, MEd, David Brent, MD, and Sandra McKenzie, PhD. Western Psychiatric Institute and Clinic, University of Pgh. (10/95). Email: birmaherb@msx.upmc.edu

Screen for Child Anxiety Related Disorders (SCARED)

Parent Version - Page 1 of 2 (To be filled out by the PARENT)

Name: _____ **Date:** _____

Directions:
Below is a list of statements that describe how people feel. Read each statement carefully and decide if it is "Not True or Hardly Ever True" or "Somewhat True or Sometimes True" or "Very True or Often True" for your child. Then for each statement, fill in one circle that corresponds to the response that seems to describe your child for the last 3 months. Please respond to all statements as well as you can, even if some do not seem to concern your child.

		0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True
1.	When my child feels frightened, it is hard for him/her to breathe	o	o	o
2.	My child gets headaches when he/she is at school	o	o	o
3.	My child doesn't like to be with people he/she doesn't know well	o	o	o
4.	My child gets scared if he/she sleeps away from home	o	o	o
5.	My child worries about other people liking him/her	o	o	o
6.	When my child gets frightened, he/she feels like passing out	o	o	o
7.	My child is nervous	o	o	o
8.	My child follows me wherever I go	o	o	o
9.	People tell me that my child looks nervous	o	o	o
10.	My child feels nervous with people he/she doesn't know well	o	o	o
11.	My child gets stomachaches at school	o	o	o
12.	When my child gets frightened, he/she feels like he/she is going crazy	o	o	o
13.	My child worries about sleeping alone	o	o	o
14.	My child worries about being as good as other kids	o	o	o
15.	When he/she gets frightened, he/she feels like things are not real	o	o	o
16.	My child has nightmares about something bad happening to his/her parents	o	o	o
17.	My child worries about going to school	o	o	o
18.	When my child gets frightened, his/her heart beats fast	o	o	o
19.	He/she gets shaky	o	o	o
20.	My child has nightmares about something bad happening to him/her	o	o	o

Screen for Child Anxiety Related Disorders (SCARED)

Parent Version - Page 2 of 2 (To be filled out by the PARENT)

		0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True
21.	My child worries about things working out for him/her	o	o	o
22.	When my child gets frightened, he/she sweats a lot	o	o	o
23.	My child is a worrier	o	o	o
24.	My child gets really frightened for no reason at all	o	o	o
25.	My child is afraid to be alone in the house	o	o	o
26.	It is hard for my child to talk with people he/she doesn't know well	o	o	o
27.	When my child gets frightened, he/she feels like he/she is choking	o	o	o
28.	People tell me that my child worries too much	o	o	o
29.	My child doesn't like to be away from his/her family	o	o	o
30.	My child is afraid of having anxiety (or panic) attacks	o	o	o
31.	My child worries that something bad might happen to his/her parents	o	o	o
32.	My child feels shy with people he/she doesn't know well	o	o	o
33.	My child worries about what is going to happen in the future	o	o	o
34.	When my child gets frightened, he/she feels like throwing up	o	o	o
35.	My child worries about how well he/she does things	o	o	o
36.	My child is scared to go to school	o	o	o
37.	My child worries about things that have already happened	o	o	o
38.	When my child gets frightened, he/she feels dizzy	o	o	o
39.	My child feels nervous when he/she is with other children or adults and he/she has to do something while they watch him/her (for example: read aloud, speak, play a game, play a sport)	o	o	o
40.	My child feels nervous when he/she is going to parties, dances, or any place where there will be people that he/she doesn't know well	o	o	o
41.	My child is shy	o	o	o

Developed by Boris Birmaher, MD, Suneeta Khetarpal, MD, Marlane Cully, MEd, David Brent, MD, and Sandra McKenzie, PhD. Western Psychiatric Institute and Clinic, University of Pgh. (10/95). Email: birmaherb@msx.upmc.edu