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

PHQ-9 modified for Adolescents (PHQ-A)

Name: _____ **Clinician:** _____ **Date:** _____

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an **"X"** in the box beneath the answer that best describes how you have been feeling.

	(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?

☐Yes ☐No

If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?

☐Not difficult at all ☐Somewhat difficult ☐Very difficult ☐Extremely difficult

Has there been a time in the **past month** when you have had serious thoughts about ending your life?

☐Yes ☐No

Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?

☐Yes ☐No

***If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.*

Office use only: **Severity score:** _____

Modified with permission from the PHQ (Spitzer, Williams & Kroenke, 1999) by J. Johnson (Johnson, 2002)

GAD-7 Screening Questions

	During the last 2 weeks, how often have you been bothered by the following problems?	not at all	several days	more than half the days	nearly every day
1	Feeling nervous, anxious, or on edge	0	1	2	3
2	Not being able to stop or control worrying	0	1	2	3
3	Worrying too much about different things	0	1	2	3
4.	Trouble relaxing	0	1	2	3
5.	Being so restless that it is hard to sit still	0	1	2	3
6.	Becoming easily annoyed or irritable	0	1	2	3
7.	Feeling afraid as if something awful might happen	0	1	2	3

Total Score: _____ = Add columns: _____ + _____ + _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

The Child PTSD Symptom Scale (CPSS) – Part I

Below is a list of problems that kids sometimes have after experiencing an upsetting event. Read each one carefully and circle the number (0-3) that best describes how often that problem has bothered you IN THE LAST 2 WEEKS.

Please write down your most distressing event:

_____

Length of time since the event:

_____

0	1	2	3
Not at all or only at one time	Once a week or less/ once in a while	2 to 4 times a week/ half the time	5 or more times a week/almost always

1.	0	1	2	3	Having upsetting thoughts or images about the event that came into your head when you didn't want them to
2.	0	1	2	3	Having bad dreams or nightmares
3.	0	1	2	3	Acting or feeling as if the event was happening again (hearing something or seeing a picture about it and feeling as if I am there again)
4.	0	1	2	3	Feeling upset when you think about it or hear about the event (for example, feeling scared, angry, sad, guilty, etc)
5.	0	1	2	3	Having feelings in your body when you think about or hear about the event (for example, breaking out into a sweat, heart beating fast)
6.	0	1	2	3	Trying not to think about, talk about, or have feelings about the event
7.	0	1	2	3	Trying to avoid activities, people, or places that remind you of the traumatic event
8.	0	1	2	3	Not being able to remember an important part of the upsetting event
9.	0	1	2	3	Having much less interest or doing things you used to do
10.	0	1	2	3	Not feeling close to people around you
11.	0	1	2	3	Not being able to have strong feelings (for example, being unable to cry or unable to feel happy)

12.	0	1	2	3	Feeling as if your future plans or hopes will not come true (for example, you will not have a job or getting married or having kids)

0	1	2	3
Not at all or only at one time	Once a week or less/ once in a while	2 to 4 times a week/ half the time	5 or more times a week/almost always

13.	0	1	2	3	Having trouble falling or staying asleep
14.	0	1	2	3	Feeling irritable or having fits of anger
15.	0	1	2	3	Having trouble concentrating (for example, losing track of a story on the television, forgetting what you read, not paying attention in class)
16.	0	1	2	3	Being overly careful (for example, checking to see who is around you and what is around you)
17.	0	1	2	3	Being jumpy or easily startled (for example, when someone walks up behind you)

The Child PTSD Symptom Scale (CPSS) – Part 2

Indicate below if the problems you rated in Part 1 have gotten in the way with any of the following areas of your life DURING THE PAST 2 WEEKS.

	Yes	No	
18.	Y	N	Doing your prayers
19.	Y	N	Chores and duties at home
20.	Y	N	Relationships with friends
21.	Y	N	Fun and hobby activities
22.	Y	N	Schoolwork
23.	Y	N	Relationships with your family
24.	Y	N	General happiness with your life

Name		Today's Date	

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by each symptom during the PAST WEEK, INCLUDING TODAY, by placing an X in the corresponding space in the column next to each symptom.

	NOT AT ALL	MIDLY It did not bother me much	MODERATELY It was very unpleasant but I could stand it	SEVERELY I could barely stand it
1. Numbness or tingling				
2. Feeling hot				
3. Wobbliness in legs				
4. Unable to relax				
5. Fear of the worst happening				
6. Dizzy or lightheaded				
7. Heart pounding or racing				
8. Unsteady				
9. Terrified				
10. Nervous				
11. Feelings of choking				
12. Hands trembling				
13. Shaky				
14. Fear of losing control				
15. Diffuculty breathing				
16. Fear of dying				
17. Scared				
18. Indigestion or discomfort in abdomen				
19. Faint				
20. Face flushed				
21. Sweating (not due to heat)				

Altman Self-Rating Mania Scale (ASRM)

Name _____ Date _____

Instructions:

1. There are 5 statements groups on this questionnaire: read each group of statements carefully.
2. Choose the one statement in each group that best describes the way you have been feeling for the past week.
3. Check the box next to the number/statement selected.
4. Please note: The word "occasionally" when used here means once or twice; "often" means several times or more and "frequently" means most of the time.

Question 1

- ☐ 0 I do not feel happier or more cheerful than usual.
- ☐ 1 I occasionally feel happier or more cheerful than usual.
- ☐ 2 I often feel happier or more cheerful than usual.
- ☐ 3 I feel happier or more cheerful than usual most of the time.
- ☐ 4 I feel happier or more cheerful than usual all of the time.

Question 2

- ☐ 0 I do not feel more self-confident than usual.
- ☐ 1 I occasionally feel more self-confident than usual.
- ☐ 2 I often feel more self-confident than usual.
- ☐ 3 I feel more self-confident than usual.
- ☐ 4 I feel extremely self-confident all of the time.

Question 3

- ☐ 0 I do not need less sleep than usual.
- ☐ 1 I occasionally need less sleep than usual.
- ☐ 2 I often need less sleep than usual.
- ☐ 3 I frequently need less sleep than usual.
- ☐ 4 I can go all day and night without any sleep and still not feel tired.

Question 4

- ☐ 0 I do not talk more than usual
- ☐ 1 I occasionally talk more than usual.
- ☐ 2 I often talk more than usual.
- ☐ 3 I frequently talk more than usual.
- ☐ 4 I talk constantly and cannot be interrupted

Question 5

- ☐ 0 I have not been more active (either socially, sexually, at work, home or school) than usual.
- ☐ 1 I have occasionally been more active than usual.
- ☐ 2 I have often been more active than usual
- ☐ 3 I have frequently been more active than usual.
- ☐ 4 I am constantly active or on the go all the time.