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 ARNP

Emily Leinen, PMHNP

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

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

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)

		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)

<u>Parent Version</u> - 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 <u>for the last 3 months</u>. 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

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