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.

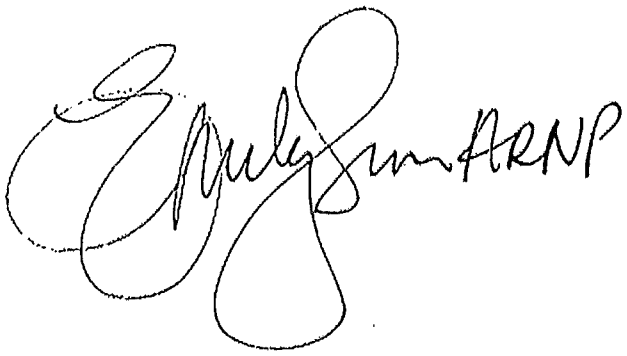
We have some important reminders to inform you of so you can have an excellent experience while visiting our office. You are very important to us, and each appointment is valuable.

- 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

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)				

PCL-5

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

Patient Name		Today's Date	

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					
					Part A
7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15. How often do you find yourself talking too much when you are in social situations?					
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?					
17. How often do you have difficulty waiting your turn in situations when turn taking is required?					
18. How often do you interrupt others when they are busy?					
					Part B

PLEASE INDICATE WHETHER **YES** OR **NO** IS THE BEST ANSWER FOR YOU:

1. Have any of your closest relationships been troubled by a lot of arguments of repeated breakups? 1 = YES 0 =NO
2. Have you deliberately hurt yourself physically (e.g. punched yourself, cut yourself, burned yourself)? How about made a suicide attempt? 1 = YES 0 =NO
3. Have you had at least 3 other problems with impulsivity (e.g. eating binges and spending sprees, drinking too much and verbal outbursts)? 1 = YES 0 =NO
4. Have you been extremely moody? 1 = YES 0 =NO
5. Have you felt very angry a lot of the time? How about often acted in an angry or sarcastic manner? 1 = YES 0 =NO
6. Have you been distrustful of other people? 1 = YES 0 =NO
7. Have you frequently felt unreal or as if things around you were unreal? 1 = YES 0 =NO
8. Have you chronically felt empty? 1 = YES 0 =NO
9. Have you often felt that you had no idea of who you are or that you have no identity? 1 = YES 0 =NO
10. Have you made desperate efforts to avoid feeling abandoned or being abandoned (e.g. repeatedly called someone to reassure yourself that he or she still cared, begged them not to leave you, clung to them physically)? 1 = YES 0 =NO

My feelings towards food and body...?

I feel out of control with my eating _____

I dislike my body _____

I am always trying to control my weight _____

I often binge eat and then try to get rid of calories _____

I skip meals to control my weight _____

I am secretive about my eating _____

I get anxious when I don't exercise _____

Others say I have lost a lot of weight in a short period of time _____

My menstrual periods are irregular or have stopped completely _____

I am scared of weight gain _____

Sometimes I vomit after eating _____

I use diet pills, laxatives or other substances to control my weight _____

I believe I am overweight even though others tell me I am not _____

I don't deserve to eat and feel guilty if I do _____

I isolate myself from others because of the way I look or because food my be involved _____

PLEASE ANSWER **YES** OR **NO** ON THE LINE FOLLOWING EACH SENTENCE.

Do you notice that your mood and/or energy levels shift drastically from time to time? _____

Do you notice that, at times, your mood and/or energy level is very low, and at other times, very high? _____

During your "low" phases, do you often feel a lack of energy; a need to stay in bed or get extra sleep; and little or no motivation to do things you need to do? _____

Do you often put on weight during these periods? _____

During low phases, do you often feel "blue," sad all the time, or depressed? _____

Sometimes, during these low phases, do you feel hopeless or even suicidal? _____

Is your ability to function at work impaired or are you socially impaired? _____

Do these low phases typically last for a few weeks, but sometimes they last only a few days? _____

Sometimes with this type of pattern, you may experience a period of "normal" mood in between mood swings, during which your mood and energy level feel "right" and your ability to function is not disturbed? _____

Do you then notice a marked shift or "switch" in the way you feel? _____

Does your energy increase above what is normal for you, and do you often get many things done that you would not ordinarily be able to do? _____

Sometimes, during these "high" periods, do you feel as if you have too much energy or feel "hyper"? _____

Do you, during these high periods, feel irritable, "on edge," or aggressive? _____

Do you, during these high periods, take on too many activities at once? _____

During these high periods, do you spend money in ways that cause you trouble? _____

Are you more talkative, outgoing, or sexual during these periods? _____

Sometimes, does your behavior during these high periods seem strange or annoying to others? _____

Do you sometimes get into difficulty with co-workers or the police, during these high periods? _____

Sometimes, do you increase your alcohol or non-prescription drug use during these high periods? _____

Now that you have read this passage, please check one of the following four boxes:

☐ This story fits me very well or almost perfectly.
☐ This story fits me fairly well.
☐ This story fits me to some degree, but not in most respects.
☐ This story does not really describe me at all.

Instructions: Check (✓) the answer that best applies to you.

	Yes	No
1. Has there ever been a period of time when you were not your usual self and...		
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	◯	◯
...you were so irritable that you shouted at people or started fights or arguments?	◯	◯
...you felt much more self-confident than usual?	◯	◯
...you got much less sleep than usual and found you didn't really miss it?	◯	◯
...you were much more talkative or spoke faster than usual?	◯	◯
...thoughts raced through your head or you couldn't slow your mind down?	◯	◯
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	◯	◯
...you had much more energy than usual?	◯	◯
...you were much more active or did many more things than usual?	◯	◯
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	◯	◯
...you were much more interested in sex than usual?	◯	◯
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	◯	◯
...spending money got you or your family in trouble?	◯	◯
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time? *Please check 1 response only.*	◯	◯
3. How much of a problem did any of these cause you — like being able to work; having family, money, or legal troubles; getting into arguments or fights? *Please check 1 response only.* ◯ No problem ◯ Minor problem ◯ Moderate problem ◯ Serious problem		
4. Have any of your blood relatives (ie, children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	◯	◯
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	◯	◯

This questionnaire should be used as a starting point. It is not a substitute for a full medical evaluation. Bipolar disorder is a complex illness, and **an accurate, thorough diagnosis can only be made through a personal evaluation by your doctor.**

Adapted from Hirschfeld R, Williams J, Spitzer RL, et al. Development and validation of a screening instrument for bipolar spectrum disorder: the Mood Disorder Questionnaire. *Am J Psychiatry*. 2000;157:1873-1875.

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	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

(For office coding: Total Score T____ = ____ + ____ + ____)

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

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**
☐	☐	☐	☐