



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 as follows:
 - Monday CLOSED
 - Tuesday and Wednesday 8:00 am-7:00 pm
 - Thursday and Friday 8:00 am-5:00 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



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	> Cellac 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.

Week	During the Past			
	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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. I did not feel like eating; my appetite was poor.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. I felt that I could not shake off the blues even with help from my family or friends.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I felt I was just as good as other people.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. I had trouble keeping my mind on what I was doing.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. I felt depressed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. I felt that everything I did was an effort.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. I felt hopeful about the future.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. I thought my life had been a failure.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. I felt fearful.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. My sleep was restless.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. I was happy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. I talked less than usual.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. I felt lonely.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. People were unfriendly.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. I enjoyed life.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. I had crying spells.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. I felt sad.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. I felt that people dislike me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. I could not get "going."	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

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	0	0	0
22.	When I get frightened, I sweat a lot	0	0	0
23.	I am a worrier	0	0	0
24.	I get really frightened for no reason at all	0	0	0
25.	I am afraid to be alone in the house	0	0	0
26.	It is hard for me to talk with people I don't know well	0	0	0
27.	When I get frightened, I feel like I am choking	0	0	0
28.	People tell me that I worry too much	0	0	0
29.	I don't like to be away from my family	0	0	0
30.	I am afraid of having anxiety (or panic) attacks	0	0	0
31.	I worry that something bad might happen to my parents	0	0	0
32.	I feel shy with people I don't know well	0	0	0
33.	I worry about what is going to happen in the future	0	0	0
34.	When I get frightened, I feel like throwing up	0	0	0
35.	I worry about how well I do things	0	0	0
36.	I am scared to go to school	0	0	0
37.	I worry about things that have already happened	0	0	0
38.	When I get frightened; I feel dizzy	0	0	0
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)	0	0	0
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	0	0	0
41.	I am shy	0	0	0

**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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2.	My child gets headaches when he/she is at school	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3.	My child doesn't like to be with people he/she doesn't know well	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4.	My child gets scared if he/she sleeps away from home	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5.	My child worries about other people liking him/her	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6.	When my child gets frightened, he/she feels like passing out	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7.	My child is nervous	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8.	My child follows me wherever I go	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9.	People tell me that my child looks nervous	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10.	My child feels nervous with people he/she doesn't know well	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11.	My child gets stomachaches at school	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12.	When my child gets frightened, he/she feels like he/she is going crazy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13.	My child worries about sleeping alone	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14.	My child worries about being as good as other kids	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15.	When he/she gets frightened, he/she feels like things are not real	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16.	My child has nightmares about something bad happening to his/her parents	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17.	My child worries about going to school	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18.	When my child gets frightened, his/her heart beats fast	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19.	He/she gets shaky	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20.	My child has nightmares about something bad happening to him/her	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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	0	0	0
22.	When my child gets frightened, he/she sweats a lot	0	0	0
23.	My child is a worrier	0	0	0
24.	My child gets really frightened for no reason at all	0	0	0
25.	My child is afraid to be alone in the house	0	0	0
26.	It is hard for my child to talk with people he/she doesn't know well	0	0	0
27.	When my child gets frightened, he/she feels like he/she is choking	0	0	0
28.	People tell me that my child worries too much	0	0	0
29.	My child doesn't like to be away from his/her family	0	0	0
30.	My child is afraid of having anxiety (or panic) attacks	0	0	0
31.	My child worries that something bad might happen to his/her parents	0	0	0
32.	My child feels shy with people he/she doesn't know well	0	0	0
33.	My child worries about what is going to happen in the future	0	0	0
34.	When my child gets frightened, he/she feels like throwing up	0	0	0
35.	My child worries about how well he/she does things	0	0	0
36.	My child is scared to go to school	0	0	0
37.	My child worries about things that have already happened	0	0	0
38.	When my child gets frightened, he/she feels dizzy	0	0	0
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)	0	0	0
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	0	0	0
41.	My child is shy	0	0	0