Middle TN Psychiatric Cooperative
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New Patient Registration

This form requests information about your child which will help us design a treatment plan geared specifically to your child's needs. Please take a few moments to complete the form carefully. We appreciate your time and effort in completing these documents. If you have any questions, please feel free to discuss them with us. Thank you.

Patient Name: _____ Birth date: _____ Today's date: _____
Address: _____ Age:_____ □ Female □Male □Trans □Non-binary
City, State, Zip: _____
Telephone (_____)_____ (_____)_____
Home Cell Phone
Mother: _____ Hm(___)_____Wk(___)_____C(___)_____
Name Phone numbers
Father: _____ Hm(___)_____Wk(___)_____C(___)_____
Name Phone numbers
Father's Address, if different from above_____
Relationship Status of Parents: □Never Married □Married/Partnership □Separated □Divorced □Widowed

Person responsible for payment: _____
Address:_____

Please list all other persons living in your household, as well as children not living in your home.

Name	Age	Relationship	Employment	Welfare (Are you on welfare aid?)
_____	_____	_____	□ yes □ no	□ yes □ no
At home / Not at home (Circle one)				
_____	_____	_____	□ yes □ no	□ yes □ no
At home / Not at home (Circle one)				
_____	_____	_____	□ yes □ no	□ yes □ no
At home / Not at home (Circle one)				
_____	_____	_____	□ yes □ no	□ yes □ no
At home / Not at home (Circle one)				

Education level (father)
□ Kindergarten
□ Elementary (grade level:____)
□ Middle Sch (grade level:____)
□ Higher Sch (grade level:____)
□ Graduate

Education level (mother)
□ Kindergarten
□ Elementary (grade level:____)
□ Middle Sch (grade level:____)
□ Higher Sch (grade level:____)
□ Graduate

_____ _____ (____)_____
Primary Care Provider Address Phone

May we exchange information with your treating providers to coordinate your care? □Yes □No
By whom were you referred?_____

Please describe your reason(s) for seeking treatment at this time (Include when the problem started):

_____

_____

Please list other health care professionals currently treating your child:_____

_____

_____

Please list current allergies or other health problems for your child:_____

_____

Please indicate past problems with a "P" and current problems with a "C"

__Depression
__Anxiety
__Stress
__Grief/Loss
__LD/ADHD
__Anger
__Obsessions/Compulsions
__Trauma
__Chronic Illness
__Chronic Pain
__Loneliness
__Eating or Weight Problem
__Abuse/victimization
__Domestic Violence
__Manic Episodes
__Legal Matters
__Relationship Issues
__Sexuality/Sexual Issues
__Family Conflict
__Behavioral Problems
__Schizophrenia/Psychosis
__Phobias/fears
__Eliminating a Drug/Alcohol Habit
__Eliminating Another Habit (eg, over-spending, gambling, etc.)

Other:_____(Please explain)

Please indicate how the problems are affecting the following areas of you and your child's life:

	No effect	Little effect	Some effect	Much effect	Significant effect	Not applicable
Relationships with peers	1	2	3	4	5	N/A
Family	1	2	3	4	5	N/A
Job/School Performance	1	2	3	4	5	N/A
Friendships	1	2	3	4	5	N/A
Financial Situation	1	2	3	4	5	N/A
Physical Health	1	2	3	4	5	N/A

Total:_____

Have you ever received mental health or substance abuse treatment before? If yes, please describe:

Type of treatment Provider Name Phone Number First Seen Last Seen

_____

_____

_____

Current Medications Dose Prescribing Provider

_____

_____

_____

Thank you for your help.