James M. Claiborn Ph.D. ABPP ACT
205 Ocean Ave Portland ME 04103
Licensed Psychologist in CA, DE, ME, NH, NY
Specializing in Cognitive Behavioral Therapy for Obsessive-Compulsive Spectrum and other Disorders
(207) 799-0408

Client Information (Adult)

Today's date: _____ Date of first appointment, if different: _____

A. IDENTIFICATION:

Your name: _____ Date of birth: _____ Age: _____

Any nicknames or aliases: _____ Social Security #: _____

Home street address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Home/evening phone: _____ E-mail: _____

Cell phone: _____ Calls and e-mails will be discreet, but please indicate any restrictions:_____

_____

People you live with (names, ages, relationship): _____

_____

B. REFERRAL: Who gave you our name to call?

Name: _____ Phone: _____ Fax: _____

Address: _____ City: _____ State: ____ Zip: _____

May we have your permission to thank this person for referring you? ☐ Yes ☐ No ☐ N/A

C. YOUR MEDICAL CARE: From whom or where do you get your medical care?

Doctor / clinic name: _____ Phone: _____ Fax: _____

Address: _____ City: _____ State: ____ Zip: _____

Date of last complete physical exam: _____ List any medical conditions you have: _____

_____

List ALL medications you take regularly: _____

Some managed care coverage requests that I contact your primary care or other medical providers. I will only do so with your written authorization. Do you want me to contact your medical providers ☐ Yes ☐ No

D. CURRENT EMPLOYMENT:

Employer: _____ For how long? _____

Address: _____ City: _____ State: ____ Zip: _____

Position (please describe what you do): _____

_____

Work phone: _____ Calls will be discreet, but please indicate any restrictions: _____

_____

E. EDUCATION AND TRAINING:

Highest grade you completed in school: _____ Year: _____ Major/best subject: _____

Please indicate any special training: _____

_____

F. SIGNIFICANT PREVIOUS EMPLOYMENT AND MILITARY EXPERIENCE:

Dates From	To	Name of military or employers	Job title or duties	Reason for leaving

G. FAMILY-OF-ORIGIN HISTORY:

Relative	Name	Current age (or age at death)	Any history mental illness?	Education	Occupation
Father					
Mother					
Sisters/					
Brothers					

List any other blood relatives with a history of mental illness:

H. CURRENT AND PREVIOUS COUNSELING, PSYCHOTHERAPY, TREATMENT:

Dates From	To	Name of therapist	Focus of treatment	What does/did treatment consist of?	Is/was it helpful?

I. CURRENT AND PREVIOUS PSYCHOTROPIC MEDICATION:

Dates From	To	Name of medication	Dosage	What is/was it intended to do?	Is/was it helpful?

Health insurance information

Company _____

Insurance Co. Address

_____

_____

Subscriber's employer
_____

Employers Address
_____
_____

Name of subscriber_____

Relationship to client_____

ID # _____

Group #_____

DOB of insured _____

DOB of Client _____

Note if there is a secondary insurance policy
please request an additional copy of this form and
provide the same information for the second insurance

I understand that I am financially responsible to Dr. Claiborn for services not covered by my insurance. I understand that I am personally responsible for missed appointments or cancellations with less than 24 hours notice.

I hereby authorize the release of any medical or other information necessary to processes claims for treatment provided by Dr. Claiborn. I authorize payments of medical benefits to Dr Claiborn.

_____ _____

Signature **Date**