

### Client Information (Child)

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

Name of person completing form and relationship to child: \_\_\_\_\_

If a second person is also completing the form, their name and relationship to child (please use separate color pen for second person's responses): \_\_\_\_\_

Are the child's parents divorced?  Yes  No (If yes, parent must produce documentation indicating that he or she has the right to bring the child for medical treatment.)

#### A. IDENTIFICATION:

Child's name (and nickname): \_\_\_\_\_ Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_

Home street address: \_\_\_\_\_ Apt.: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home/evening phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Parents' e-mail: \_\_\_\_\_ Child's e-mail: \_\_\_\_\_

Calls and e-mails will be discreet, but please indicate any restrictions: \_\_\_\_\_

Please list all people and animals the child lives with (names, species, relationship, ages of siblings): \_\_\_\_\_

#### 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. CHILD'S MEDICAL CARE: From whom or where do you get your child's medical care?

Doctor / clinic name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

If your child enters treatment with us, may we inform his or her physician to coordinate our treatment?  Yes  No

Date of last complete physical exam: \_\_\_\_\_ List any medical conditions your child has: \_\_\_\_\_

List ALL medications your child takes regularly: \_\_\_\_\_

**D. MOTHER:** (Please write "same" if any information is the same as in section A)

Mother's name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_  
Any nicknames or aliases: \_\_\_\_\_ Home/evening phone: \_\_\_\_\_  
Home street address: \_\_\_\_\_ Apt.: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Mother's e-mail: \_\_\_\_\_ Mother's cell phone: \_\_\_\_\_  
Highest grade completed in school: \_\_\_\_\_ Year: \_\_\_\_\_ Major/best subject: \_\_\_\_\_  
Please indicate any special training: \_\_\_\_\_  
Mother's 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. FATHER:** (Please write "same" if any information is the same as in section A)

Father's name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_  
Any nicknames or aliases: \_\_\_\_\_ Home/evening phone: \_\_\_\_\_  
Home street address: \_\_\_\_\_ Apt.: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Father's e-mail: \_\_\_\_\_ Father's cell phone: \_\_\_\_\_  
Highest grade completed in school: \_\_\_\_\_ Year: \_\_\_\_\_ Major/best subject: \_\_\_\_\_  
Please indicate any special training: \_\_\_\_\_  
Father's 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: \_\_\_\_\_  
\_\_\_\_\_

**F. CHILD'S BIOLOGICAL FAMILY HISTORY:**

Biological Relative	Name (and age if not already given)	Any history of OCD or mental illness?
Father:	_____	_____
Mother:	_____	_____
Siblings:	_____	_____
Others:	_____	_____
	_____	_____
	_____	_____

**G. CHILD'S CURRENT AND PREVIOUS COUNSELING, PSYCHOTHERAPY, TREATMENT:**

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

**H. CHILD'S CURRENT AND PREVIOUS PSYCHOTROPIC MEDICATION:**

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

**I. CHILD'S MEDICAL/DEVELOPMENTAL HISTORY:** List any significant medical or developmental problems, hospitalizations, residential placements, Foster homes, etc.: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**J. CHILD'S INTERESTS, SCHOOL, ETC.**

Favorite activities, hobbies, recreation, TV shows, etc.: \_\_\_\_\_  
\_\_\_\_\_  
Favorite foods: \_\_\_\_\_  
Other talents, skills, interests: \_\_\_\_\_  
School performance, grades: \_\_\_\_\_  
Favorite subject(s): \_\_\_\_\_  
May we discuss your child with his or her teacher?  No  Yes, teacher's name: \_\_\_\_\_  
Name and phone number of school: \_\_\_\_\_

**K. OTHER:** Is there anything else you think might be helpful that doesn't appear on this or another form? \_\_\_\_\_

Health insurance information

Company \_\_\_\_\_

Name of subscriber \_\_\_\_\_

Insurance Co. Address

Relationship to client \_\_\_\_\_

\_\_\_\_\_

ID # \_\_\_\_\_

\_\_\_\_\_

Group # \_\_\_\_\_

DOB of insured \_\_\_\_\_

Subscriber's employer

\_\_\_\_\_

DOB of Client \_\_\_\_\_

Employers Address

\_\_\_\_\_

\_\_\_\_\_

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**