James M. Claiborn Ph.D. ABPP ACT
Licensed Psychologist in CA, DE, ME, NH, NY, VT
205 Ocean Ave, Portland, ME 04103
7 W. Figueroa, Suite 300 Santa Barbara CA 93101
Specializing in Cognitive Behavioral Therapy for Obsessive-Compulsive
Spectrum and other Disorders
207 799-0408 or 866 205-8728

Client Information (Child)

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 (nickname, pronouns): _____ 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 From	Dates To	Name of therapist	Focus of treatment	What does/did treatment consist of?	Is/was it helpful?

H. CHILD'S CURRENT AND PREVIOUS PSYCHOTROPIC MEDICATION:

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

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 _____

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 hour notice.

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

_____ _____

Signature **Date**