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 Barara CA 93101
Specializing in Cognitive Behavioral Therapy for Obsessive-Compulsive Spectrum and other Disorders
207 799-0408 or 866 205-8728

Client Information (Adult)

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

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): _____

_____

A. 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

B. 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

C. 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: _____

_____

D. EDUCATION AND TRAINING:

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

Please indicate any special training: _____

_____

E. SIGNIFICANT PREVIOUS EMPLOYMENT AND MILITARY EXPERIENCE:

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

F. 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 mental illness:

G. 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?

H. 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 _____ 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

_____ either copy this page or 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 process claims for treatment provided by Dr. Claiborn. I authorize payments of medical benefits to Dr Claiborn.

_____ _____

Signature Date

Rev 4/23