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Licensed Psychologist in CA, DE, ME, NH, NY, VT
205 Ocean Ave, Portland, ME 04103
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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	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	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

____

Employer's 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**

Please direct mail to 7 W. Figueroa St, Suite 300, Santa Barbara, CA 93101

To email your forms, click my email address: **anxietyshrink@gmail.com** and attach your completed forms.