**THE SOLUTION CENTER, LLC**  Daphne J. Schuster, Ed.D., LCSW-R, LMFT [ ]

*100 Manetto Hill Road, Suite 307*  Patricia D. Travaglione, LCSW-R [ ]

*Plainview, NY   11803*  Kristen Billig, LCSW [ ]

*516-650-6478*  Caitlin Goetz, LMSW [ ]

 Kristen Whalen, LMSW [ ]

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**CLIENT INTAKE FORM**

***NAME:***­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ***DOB:***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *Address:*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *Home #:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_ \****Cell #****:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\**E-mail address****: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***NAME:***­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ***DOB:***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *Address*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *Home #:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_ \****Cell #:*** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\**E-mail address****:****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*School (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

***Method of Referral***:

*Web: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Acquaintance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Please note the following policies***:

All sessions are scheduled for 45 minutes, and for 40 minutes for children under ten.

All cancellations require 24 hours’ notice. Clients are responsible for the full session fee for all missed appointments without the prior 24-hour notification, unless the session **can be rescheduled within the same week.**

Please feel free to discuss any questions regarding these policies with your therapist.

Thank you.

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**For Office Use Only:**

Date of Initial Visit: \_\_\_\_\_\_\_\_\_\_\_ Dx: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DSMV code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_