# ISI THERAPEUTIC FAMILY SERVICES, LLC
# INTAKE FORM

**Please complete the entire packet prior to your first appointment.**

**Patient Name**: ------------------------------------------------------- Today's Date: --------------------

Birth date: ----------------------------------------------- Social Security Number: ---------------------

Address: ---------------------------------------------------------------------------------------------------

City, State: ---------------------------------------------------- Zip: ---------------------------------------

Phone Numbers: Home: (--------)-------------- Work: (----)-------------- Cell: (-----)-------------

Marital/Relationship Status:-------------------------- Significant Other's Name: ---------------------

## (If patient is under 18) Parent/legal guardian's name(s): ----------------

Birth Date: --------------------------- Social Security Number: ------------------------------------------

Custody Status (if applicable) ----------------------------------------------------------------------------

School: ------------------------------------- Grade: ------------------------ Teacher: ---------------------

**PARENT:** List the name and location of your children (including adult and step-children below):

Name Age DOB Gender Location

----------------------------------------------------------- M F ------------------------------------------

----------------------------------------------------------- M F ------------------------------------------

----------------------------------------------------------- M F ------------------------------------------

----------------------------------------------------------- M F ------------------------------------------

----------------------------------------------------------- M F ------------------------------------------

Who else lives with you and what is their relationship? -----------------------------------------------------------------------
-------------------------------------------------------------------------------------------------------------------------------

Who shall we contact in case of emergency? Name: ------------------------------------- Phone: -----------------------------

Relationship to the patient: ------------------------------------------------------------------------------------------------------

Who referred you to Chad Smith, M.A., LMFT? ---------------------------------------------------------------------------------