Tango & Co.

Therapy

Where resilience and connection grow

Individual Intake Form

Tango & Co. Therapy | Carrie Soto Erickson, MS, LMFT

All information provided is strictly confidential and protected under HIPAA and Washington State law (RCW 70.02).

Date of First Appointment: **Date of Birth:**

Full Legal Name: **Preferred Name:**

Pronouns: **Phone:**

Email: **Best way to contact you:**

How Did You Hear About Us?

- ☐ My Website
- ☐ Psychology Today
- ☐ Friend / Family
- ☐ Primary Care Provider
- ☐ Insurance Directory
- ☐ Social Media
- ☐ Other

If Other / Referred by:

Medical Provider:

Insurance Provider:

Previous Mental Health Services

Have you previously received any type of mental health services?

☐ Yes ☐ No

If yes, please check all that apply:

- ☐ Individual Therapy
- ☐ Couples / Family Therapy
- ☐ Psychiatric Medication
- ☐ Outpatient Program
- ☐ Inpatient / Residential
- ☐ Group Therapy
- ☐ Crisis Services
- ☐ Other

Name of Provider or Facility: **Location:** **Dates of Treatment:**

What Brings You In Today?

Please share as much or as little as you feel comfortable with. There are no right or wrong answers — this helps Carrie S. Erickson, LMFT understand where you are and how to best support you.

In your own words, what is bringing you to therapy at this time?

When did you first notice this concern?

- ☐ Within the last 30 days
- ☐ 1–6 months ago
- ☐ 6–12 months ago
- ☐ 1–2 years ago
- ☐ During adolescence
- ☐ During childhood
- ☐ It's always been present
- ☐ Not sure

What areas of your life have been most affected?

(e.g., work, relationships, health, daily functioning)

Your Goals for Therapy

Understanding what you hope to accomplish helps Carrie S. Erickson, LMFT tailor your treatment to what matters most to you.

What would you most like to change, heal, or grow in through therapy?

What would your life look, feel, or function like if therapy were successful for you?

Are there specific skills, tools, or insights you are hoping to gain?

How soon are you hoping to see progress?

- ☐ Right away — I'm in crisis
- ☐ Within the next few weeks
- ☐ Over several months
- ☐ I'm open to whatever it takes
- ☐ I'm not sure yet

Is there anything you are NOT hoping to do or discuss in therapy? (Optional)

Has anything gotten in the way of therapy being helpful for you in the past? (Optional)

Current Emotional & Mental Health

Are you currently experiencing overwhelming sadness, grief, or depression? ☐ Yes ☐ No

If yes, approximately how long:

Are you currently experiencing anxiety, worry, panic attacks, or phobias? ☐ Yes ☐ No

If yes, when did this begin:

Are you currently experiencing any of the following? (Check all that apply)

- ☐ Mood swings
- ☐ Irritability / anger
- ☐ Hopelessness
- ☐ Low self-worth
- ☐ Intrusive thoughts
- ☐ Flashbacks / trauma responses
- ☐ Dissociation
- ☐ Difficulty concentrating
- ☐ Social withdrawal
- ☐ Numbness / emptiness
- ☐ Obsessive thoughts / compulsions
- ☐ Hearing/seeing things others don't
- ☐ Paranoia / hypervigilance
- ☐ Impulsivity
- ☐ Self-harm urges
- ☐ Suicidal thoughts

Have you had thoughts of suicide or self-harm recently? ☐ Yes ☐ No

If yes, please describe (current plan, frequency, intensity):

Please describe any major losses, traumas, or difficult experiences you have had:

What significant life changes or stressors are you currently facing?

Family Background

Where were you born?

Where did you grow up?

Describe the environment you grew up in:

- ☐ Urban / City
- ☐ Suburban
- ☐ Rural / Country
- ☐ Moved around frequently
- ☐ Lived abroad

Who did you live with while growing up?

Please list parents, caregivers, and siblings:

Name	Age	Relationship	Where do they live now?	If deceased, age & cause

Family history of any of the following? Check yes or no and note the family member's relationship to you.

Condition	Yes	No	Family Member (relationship)
Alcohol / Substance Use	☐	☐	
Anxiety	☐	☐	
Depression	☐	☐	
Domestic Violence	☐	☐	
Sexual Abuse	☐	☐	
Eating Disorders	☐	☐	
Obesity	☐	☐	
OCD	☐	☐	
Schizophrenia / Psychosis	☐	☐	
Suicide Attempts	☐	☐	
Bipolar Disorder	☐	☐	
ADHD / Learning Differences	☐	☐	
Other Mental Health Condition	☐	☐	

Relationships & Social Support

Current relationship status:

- ☐ Single
- ☐ In a relationship
- ☐ Partnered (unmarried)
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed
- ☐ It's complicated
- ☐ Prefer not to say

If partnered / married, partner's name & how long together:

_____

How would you rate your current relationship satisfaction?

1 — Unsatisfied | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 10 — Satisfied

Please list any children, their names, and ages:

Name	Age	Relationship to you	Other parent / guardian	If deceased, age & cause

Who are the most important people in your support system right now?

_____

_____

Are there any current relationship conflicts or concerns you'd like to address in therapy?

_____

_____

Physical Health

How would you rate your overall physical health?

1 — Poor | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 10 — Excellent

Please list any current health concerns:

Current medications, supplements, or herbs — include condition, dosage, and prescribing provider.

Medication / Supplement	Dosage	Condition / Purpose	Prescribing Provider

How would you rate your current sleep quality?

1 — Poor | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 10 — Excellent

If experiencing sleep difficulties, check all that apply:

- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ Waking too early
- ☐ Sleep apnea
- ☐ Nightmares / night terrors
- ☐ Sleeping too much
- ☐ Irregular schedule

How many days/week do you exercise?

Types of exercise:

Are you currently experiencing any chronic pain or physical conditions that affect daily life? ☐ Yes ☐ No

If yes, please describe:

Please describe your current use of alcohol, cannabis, tobacco, or other substances:

Please describe any past substance use that felt problematic or that you've received help for:

About You

These questions help Carrie S. Erickson, LMFT understand the full picture of who you are — your strengths, values, and what brings meaning to your life.

What do you enjoy about your work or daily role? (Homemakers, students, and retirees included)

What do you find most stressful about your current work or life situation?

What do you enjoy doing in your free time? What helps you recharge or relax?

Do you consider yourself spiritual, religious, or guided by a particular belief system or worldview? ☐ Yes ☐ No

If yes, please describe:

What are some of your greatest personal strengths?

What are some areas you'd like to grow in or feel are currently holding you back?

Is there anything else you'd like Carrie S. Erickson, LMFT to know about you before your first session?

Identity & Cultural Background (Optional)

Tango & Co. Therapy is an affirming, inclusive practice. You are warmly invited to share any aspects of your identity that feel relevant to your care. All responses are optional.

Racial / Ethnic Identity: **Gender Identity:**

Sexual Orientation: **Primary Language(s):**

Any cultural, religious, or community considerations important to your care:

Client Signature: **Date:**