



# Tango & Co.

## Therapy

Where resilience and connection grow

### Family Therapy Intake Form

Carrie Soto Erickson, MS, LMFT | Tango & Co. Therapy  
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*Please complete this form as fully as possible before your first session. All information is confidential and protected under HIPAA and Washington State law (RCW 70.02). Write N/A where a question does not apply.*

#### 1. Contact Information

Today's Date \_\_\_\_\_ Intake Date \_\_\_\_\_ Referred By \_\_\_\_\_

Primary Contact / Responsible Party — Full Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Home Address (Street, City, State, Zip) \_\_\_\_\_

Cell Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Email Address \_\_\_\_\_ Best Way to Reach You \_\_\_\_\_

Call     Text     Email     No Preference

OK to leave a voicemail? \_\_\_\_\_ Relationship to Family \_\_\_\_\_

Yes — voicemail OK     No — do not leave voicemail     Text only

Emergency Contact Name \_\_\_\_\_ Phone \_\_\_\_\_

Relationship to Client \_\_\_\_\_ OK to leave voicemail? \_\_\_\_\_

## 2. Family Members

List everyone in your household or family who may be involved in therapy. Include people who may attend only occasionally.

Name	Date of Birth	Age	Relationship to Primary Contact

Total people in household

Ages of children living at home

Languages spoken at home

## 3. Presenting Concerns

Check everything that applies to your family right now:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Communication difficulties    | <input type="checkbox"/> Parent–child conflict          | <input type="checkbox"/> Sibling conflict              |
| <input type="checkbox"/> Divorce / separation          | <input type="checkbox"/> Co-parenting challenges        | <input type="checkbox"/> Blended family adjustment     |
| <input type="checkbox"/> Grief or loss                 | <input type="checkbox"/> Trauma / PTSD                  | <input type="checkbox"/> Anxiety                       |
| <input type="checkbox"/> Depression                    | <input type="checkbox"/> Behavioral issues (child/teen) | <input type="checkbox"/> School or academic problems   |
| <input type="checkbox"/> Substance use                 | <input type="checkbox"/> Domestic violence / abuse      | <input type="checkbox"/> Major life transition         |
| <input type="checkbox"/> Infidelity / trust issues     | <input type="checkbox"/> Anger / conflict management    | <input type="checkbox"/> Cultural or identity concerns |
| <input type="checkbox"/> Self-harm / suicidal ideation | <input type="checkbox"/> Eating or body image concerns  | <input type="checkbox"/> LGBTQIA+ family concerns      |
| <input type="checkbox"/> Financial or housing stress   | <input type="checkbox"/> Medical / chronic illness      | <input type="checkbox"/> Other — describe below        |

Any other concerns, or details you'd like to add:

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#### 4. Reason for Seeking Therapy

In your own words, what brings your family to therapy right now?

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How long has this been a concern?

Have you tried therapy before?

Yes     No

If yes — describe previous therapy and what was helpful or not:

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What would a successful outcome look like for your family?

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#### 5. Family History & Structure

Relationship status of primary caregivers

Length of relationship

Married     Partnered     Separated     Divorced     Co-parenting     Single Parent     Widowed   

Describe your family structure (e.g., blended, multigenerational, single-parent):

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Are there active custody or court orders?

Yes — describe below     No

Custody / legal details:

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Significant family history relevant to current concerns (mental health, substance use, trauma, major losses, domestic violence):

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Is any family member currently seeing another therapist or provider? If yes, who and where?

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Is any family member on psychiatric medication?

Yes — list below       No

Medication(s), dose, who is prescribed, prescribing provider:

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## 6. Goals & Family Strengths

What are the top 1–3 things your family most wants to work on in therapy?

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Are there any topics the family does NOT want to discuss in therapy?

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What does your family do well? What are your greatest strengths together?

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What has helped your family get through difficult times in the past?

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Is faith, spirituality, or cultural practice important to your family? If yes, how would you like it incorporated into therapy?

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## 7. Safety Screening

Please check any that currently apply to any family member:

- Thoughts of suicide or self-harm
- Past suicide attempt(s) or self-harm history
- Thoughts of harming another person
- Current or recent domestic violence or abuse
- Active substance use concerns
- Child Protective Services (CPS) involvement — current or past
- None of the above

If any items above were checked, please describe (who, current status, any prior treatment or support):

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## 8. Anything Else?

Is there anything else Carrie S. Erickson, LMFT should know before your first session?

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How did you hear about Tango & Co. Therapy?

Preferred session format

- In-Person     Telehealth     No Preference

## 9. Signatures

*By signing below, I/we confirm that the information provided in this form is accurate to the best of my/our knowledge.*

Client / Parent or Guardian #1 Signature

Date

Printed Name

Client / Parent or Guardian #2 Signature

Date

Printed Name

Minor Client Signature (age 13 or older — RCW 71.34.530)

Date

Parent / Guardian Signature (signing on behalf of minor)

Date

Relationship to Minor

*I, Carrie S. Erickson, LMFT, have reviewed this intake with the client(s) and/or their representative and have no reason to believe any party is not fully competent to provide accurate information.*

Carrie Soto Erickson, M.S., LMFT

Date