



# Tango & Co.

## Therapy

Where resilience and connection grow

### Teen & Young Adult 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).

Welcome! This form is for you — the person coming to therapy. There are no right or wrong answers. You don't have to share anything you aren't ready to share yet. The goal is just to help Carrie S. Erickson, LMFT get to know you a little before you meet. Take your time, and answer in whatever way feels honest and comfortable.

**Note for parents/guardians:** A separate Parent/Guardian Information section is included at the end of this form. Under Washington State law (RCW 71.34.530), clients age 13 and older may consent to outpatient mental health treatment independently. Their records are confidential unless they choose to share them.

#### About You

Full Legal Name:

Date of Birth:

What name do you go by?

Age:

Your Pronouns:

Grade / Year in school:

Phone / Best contact:

Email:

School or College:

City:

#### Who do you live with?

Both parents / guardians

One parent / guardian

Split between two homes

Extended family (grandparent, aunt/uncle, etc.)

Foster family

On my own / independently

College dorms / housing

With a partner

Other

If other or anything to add:

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## What's Going On?

*This section is just for you. Answer however feels right — a few words or a lot, whatever is honest.*

**In your own words — what's been going on that made you (or someone in your life) think therapy might help?**

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**How long have things felt this way?**

- |  |                                      |  |
|--|--------------------------------------|--|
| <input type="checkbox"/> Just recently | <input type="checkbox"/> A few weeks | <input type="checkbox"/> A few months              |
| <input type="checkbox"/> About a year  | <input type="checkbox"/> A few years | <input type="checkbox"/> As long as I can remember |

**What parts of your life have been most affected? (school, friendships, family, sleep, work, etc.)**

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**Whose idea was it to come to therapy?**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Mine                  | <input type="checkbox"/> A parent / guardian | <input type="checkbox"/> A school counselor or teacher |
| <input type="checkbox"/> A doctor or counselor | <input type="checkbox"/> A friend            | <input type="checkbox"/> It was mutual / we agreed     |

**How do you feel about being here? (Excited? Nervous? Unsure? That's all okay.)**

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## What Do You Want From Therapy?

*There's no pressure to have it all figured out — even a general sense of what you're hoping for is helpful.*

**If therapy really worked for you, what would be different in your life?**

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**What do you most want help with right now?**

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**What are you hoping therapy will be like? (Check all that apply)**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> A safe place to talk without judgment              | <input type="checkbox"/> Help managing emotions                  | <input type="checkbox"/> Tools for anxiety, stress, or worry |
| <input type="checkbox"/> Support through a hard situation                   | <input type="checkbox"/> Help with relationships or social stuff | <input type="checkbox"/> Understanding myself better         |
| <input type="checkbox"/> Support with identity (gender, sexuality, culture) | <input type="checkbox"/> Coping with trauma or past experiences  | <input type="checkbox"/> Help with school or work stress     |
| <input type="checkbox"/> Figuring out my direction in life                  | <input type="checkbox"/> Support with family dynamics            | <input type="checkbox"/> Something else entirely             |

**Is there anything you definitely DON'T want therapy to be, or topics you're not ready to go near yet?**

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**Is there anything you're worried about when it comes to therapy?**

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## How Are You Feeling Lately?

Check anything that feels true for you right now, even if only sometimes.

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Sad or down                         | <input type="checkbox"/> Anxious or worried                  | <input type="checkbox"/> Angry or irritable               |
| <input type="checkbox"/> Numb or empty                       | <input type="checkbox"/> Lonely                              | <input type="checkbox"/> Overwhelmed                      |
| <input type="checkbox"/> Hopeless                            | <input type="checkbox"/> Stressed out                        | <input type="checkbox"/> Confused about who I am          |
| <input type="checkbox"/> Disconnected from others            | <input type="checkbox"/> Low energy / unmotivated            | <input type="checkbox"/> Trouble concentrating            |
| <input type="checkbox"/> Like I don't fit in                 | <input type="checkbox"/> Ashamed or guilty                   | <input type="checkbox"/> Like something is wrong with me  |
| <input type="checkbox"/> Pressured (by family, school, etc.) | <input type="checkbox"/> Like I have to be perfect           | <input type="checkbox"/> Grieving or going through a loss |
| <input type="checkbox"/> Scared at home or in a relationship | <input type="checkbox"/> Pretty okay, just want some support |   |

Overall, how would you rate your emotional wellbeing right now?

1 — Really struggling

1	2	3	4	5	6	7	8	9	10
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10 — Doing really well

**Is there anything specific that's been weighing on you the most lately?**

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Have you had any thoughts of hurting yourself or not wanting to be here?

- Yes    No

**If yes — can you tell us a little more? (When, how often, any plan?)**

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**If you are currently in crisis, please let Carrie S. Erickson, LMFT know immediately. You can also call or text 988 (Suicide & Crisis Lifeline) at any time.**

Have you ever harmed yourself (cutting, burning, etc.)?

- Yes    No

**If yes — are you currently doing so?**

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## School, Work & Social Life

Current school / program: \_\_\_\_\_

Grade / Year: \_\_\_\_\_

Are you working?  Yes  No If yes, where / how many hours: \_\_\_\_\_

How would you rate your experience at school or work right now?

1 — Really hard

1	2	3	4	5	6	7	8	9	10
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10 — Going great

**What's going well at school or work? What's been hard?**

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**What does your social life look like? Do you have close friends or people you trust?**

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**Have you experienced bullying, exclusion, or conflict with peers? (Online or in person)**

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Are you currently in a romantic relationship?

Yes  No

**If yes — how long, and is it going well?**

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## Family & Home Life

How would you describe your relationship with your parent(s) or guardian(s)?

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What's your home life like — what's it like being there?

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Are there any big changes or stresses happening in your family right now?

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Have you ever experienced abuse, neglect, or felt unsafe at home?

Yes    No

**Family history — check if any family members have experienced:**

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Depression or anxiety | <input type="checkbox"/> Substance use    | <input type="checkbox"/> Mental health conditions | <input type="checkbox"/> Trauma                     |
| <input type="checkbox"/> Domestic violence     | <input type="checkbox"/> Suicide attempts | <input type="checkbox"/> Divorce or separation    | <input type="checkbox"/> Other significant hardship |

Anything else about your family situation that feels important to share?

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## Identity & Who You Are

*Tango & Co. Therapy is a fully affirming, judgment-free space. You are welcome here exactly as you are. These questions are optional — share only what feels right.*

**How would you describe yourself? What feels most important to your identity?**

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**Gender Identity:**

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**Pronouns (we want to get it right):**

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**Sexual Orientation (optional):**

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**Racial / Ethnic Background:**

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**Spiritual / Religious / Cultural beliefs (if important to you):**

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**Is there anything about your identity that you feel has made life harder, or that you'd like support around?**

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## Physical Health

How would you rate your physical health right now?

1 — Not good

1	2	3	4	5	6	7	8	9	10
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10 — Really good

**Any medical conditions, diagnoses, or physical health concerns:**

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**Current medications (include dosage and what they're for):**

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How are you sleeping?

1 — Really poorly

1	2	3	4	5	6	7	8	9	10
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10 — Really well

How regularly are you eating?

1 — Very irregularly

1	2	3	4	5	6	7	8	9	10
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10 — Consistently and well

**Have you had any concerns about food, eating, or your body image?**

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**Do you use alcohol, cannabis, vaping, or other substances? If so, tell us a bit about it:**

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**How many hours per day do you typically spend on social media or screens (outside school)?**

Less than 1 hour

1–2 hours

3–4 hours

5–6 hours

7+ hours

I'm not sure

**Does social media feel positive, negative, or complicated for you? Tell us more if you'd like:**

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## Your Strengths & What You Enjoy

What are you good at? What do people say is great about you?

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What do you enjoy doing? What helps you feel better when things are hard?

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Who or what gives you strength, comfort, or a sense of belonging?

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

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## PARENT / GUARDIAN SECTION

To be completed by a parent or guardian (when applicable). Under Washington State law (RCW 71.34.530), clients age 13 and older may consent to therapy independently. If the client has consented independently, this section is optional.

### Parent / Guardian Contact Information

Parent/Guardian #1 Name:

Relationship:

Phone:

Email:

Parent/Guardian #2 Name:

Relationship:

Phone:

Email:

Emergency Contact (if different):

Phone:

### Parent / Guardian Perspective

*These questions are for the parent or guardian's perspective. The client's responses above are separate and confidential.*

**From your perspective, what is bringing your child/dependent to therapy?**

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**How long have you noticed these concerns? What have you already tried?**

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**What are your goals for your child/dependent through this therapy?**

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**What are your child/dependent's greatest strengths?**

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Has your child/dependent received any mental health services before?

Yes    No

If yes — provider, dates, and reason:

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Please share any relevant medical, developmental, or educational history (diagnoses, IEP/504, medications, hospitalizations):

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Are there any family stressors or changes we should be aware of?

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Is there anything else you'd like Carrie S. Erickson, LMFT to know?

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### How Did You Hear About Us?

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Website               | <input type="checkbox"/> Psychology Today    | <input type="checkbox"/> Friend / Family | <input type="checkbox"/> School counselor / teacher |
| <input type="checkbox"/> Primary care provider | <input type="checkbox"/> Insurance directory | <input type="checkbox"/> Social media    | <input type="checkbox"/> Other                      |

If referred, by whom:

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Medical Provider (if applicable):

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Insurance Provider (if applicable):

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