Dr. John Carosso, Psy.D. & Associates, Inc.
Community Psychiatric Centers / Autism Center of Pittsburgh
Dyslexia Diagnostic & Treatment Center

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Version 1.22.2026

Hello From Dr. John Carosso!

I look forward to working with you to meet the needs of your child. In preparation for our time together, here are some things to consider:

- If you will not be completing the Intake Form online (see Page 4 below), then it's best to arrive 15 minutes early to complete the intake in the reception area. The intake is very helpful in providing me with more information about your child's history and current functioning.

- Prior to the evaluation, you'll also be emailed links to complete some behavioral or developmental protocols regarding your child. It would be very helpful if those protocols were completed prior to the appointment. If not, that's okay, we'll get them completed during the office visit.

- Please bring your child to the evaluation and the child's insurance card.

- Feel free to bring any prior reports or behavioral forms completed by teachers.

- The evaluation will initially entail me talking with you, while your child works with my Assistant (my "friend") who will complete various child-friendly assessments.

- After confidentially speaking with you to obtain information about the clinical history and current concerns regarding your child, I'll join my Assistant with your child to further the evaluation process and, thereafter, you and I will discuss my formulation, recommendations, and a thorough 'game-plan', and then conclude the evaluation session. Thereafter, in about two weeks, you'll receive a comprehensive report.

- If your child is already receiving IBHS services, feel free to invite the Behavioral Consultant or Mobile Therapist.

- Feel free to call me ahead of time, at 724-787-0497, with any questions.

- If you wish to find out more information about me and the evaluation process, visit my channel on YouTube: https://www.youtube.com/watch?v=ePLZdG2DHtI

Thank you for your time with these considerations. I look forward to seeing you and your child. God bless.

Dr. John Carosso Psy.D.

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CONSENT TO TREATMENT AND RELEASE OF REPORT

My signature below attests that I give consent for my child to be seen by Dr. John Carosso, Licensed Psychologist, and Dr. Carosso's Practice Associate from Dr. Carosso & Associates, and/or from Community Psychiatric Centers for a psychological and/or psycho-educational evaluation of my child.

Psychological Evaluation of my child: _____

I understand that Dr. Carosso will conduct an evaluation of my child for the presenting problem(s) in accordance with ethical principles and research-based best practices. In this regard, an 'evaluation' will consist of a clinical interview of my child, a review of the developmental history with me (the parent), and the 'testing' process may include an assessment of intelligence, academic skills, visual-motor functioning, developmental levels, language, sensory issues, and social-emotional functioning.

Dr. Carosso may also reach out, with my signed consent, to others who have contact with my child, such as his/her teacher or therapist. I understand that the evaluation process will conclude with Dr. Carosso providing his clinical opinion regarding the formulation and diagnosis. I understand that Dr. Carosso will thoroughly explain his rationale for the diagnosis and treatment options and will work at length to ensure that I'm on the same page' in that respect. However, I understand I may or may not agree with his opinion and I understand that I can get a second opinion if I so choose. I also understand that Dr. Carosso prioritizes providing clear and concise feedback regarding a diagnosis and course of treatment, but I also recognize that he may not offer a final diagnosis at the time of the evaluation pending his reaching out to my child's teacher or therapist for further information.
Dr. Carosso may also provide suggestions in terms of a course of treatment, and I realize I may not agree or wish to pursue the suggested treatment, and I recognize it's up to me, as my child's parent, to ultimately make such treatment decisions.

I acknowledge that I am having my child seen by Dr. Carosso for an evaluation, not specifically for counseling or therapy. During the evaluation process, various treatment options will be discussed, and I may decide to obtain therapy for my child; Dr. Carosso can help facilitate the process of finding a therapist. Depending on the issues at hand, Dr. Carosso may discuss outpatient counseling, or in-home or in-school services. If I wish to immediately pursue outpatient therapy while waiting for the evaluation, or forego an evaluation in favor of simply beginning outpatient therapy, I understand I can reach out directly to his office at 724 850 7200 to make such arrangements. I understand that Dr. Carosso has produced abundant content including posts and his eBooks, available at HelpForYourChild.com, for the purposes of providing parents with helpful information to assist in managing their child's behavioral and developmental challenges. I also understand that Dr. Carosso may provide a referral for treatment services, if such is indicated, those treatment services typically would include in-office outpatient counseling, IBHS in-home or in-school services, in-home Family Based services, or a Social Skills Group.

I am aware that Dr. Carosso, Psy.D. has a doctorate in the field of Psychology, is licensed as a Psychologist in the State of PA (www.psychologyinfo.com/directory/PA/board), and has over 30 years of experience in the field working with children and teens. He has a Certification in School Psychology, a Graduate Certificate in Applied Behavioral Analysis in Special Education, and a Graduate Certificate as a Trauma Specialist. He specializes in evaluating and providing treatment for children and teenagers but also has extensive experience in providing evaluations and treatment of adults and does so on a regular basis. Dr. Carosso works in private practice (Dr. John Carosso, Psy.D. & Associates, Inc) is a partner at the mental health agency, Community Psychiatric Centers, and partner at the Autism Center of Pittsburgh.

Confidentiality and Release of Report

I am aware that the evaluation will be provided in an atmosphere of trust and, as such, all information will be kept confidential. However, I am aware that the evaluation report containing clinical information will be sent to relevant agencies including the child's pediatrician. If in-home or in-school treatment services are requested, my signature below reflects my understanding that the report will need to be submitted to the relevant County Behavioral and Developmental Unit to begin services. I am aware that Dr. Carosso will discuss these issues (where the report needs to be sent and will obtain your approval) prior to submitting the report to any outside entity or person. I am aware I can make Dr. Carosso aware of any specific pieces of information that I do not want to be included in the final report or if I do not want the report released. I am aware that I have access to my HIPAA privacy rights.

My signature below reflects my awareness that, in the case of my child or I presenting as a danger to self or others, or in the case of child abuse, that this information will need to be disclosed to the proper authorities. However, I have been informed that these issues may first be discussed with me before being disclosed to relevant others.

Costs for Services

I understand the fee arrangements and that an "evaluation" can range in cost from $80.00 (a clinical interview) to $800.00 or more (for a clinical interview and psychological/psycho-educational testing). I understand that my insurance will be billed; out-of-pocket payment will be discussed and agreed upon prior to evaluation. I give permission for Dr. John Carosso to bill my insurance company, and/or the funding source, and I understand that I am responsible for paying if the evaluation is not covered by insurance, and/or the co-pay, that will be billed after the evaluation. I understand the importance of checking with my child's insurance company prior to the evaluation to ensure coverage.

Appointments and Emergencies

I am aware of the importance of keeping the appointment and, if I cannot attend the evaluation, to provide at least 48 hours notice. In case of emergencies, I have been informed to contact 911; and that I can also contact the Practice of Dr. Carosso, at any time, at 724-787-0497. If there is no answer, I have been informed to leave a message on voice mail (picks up after five or six rings) and the call will be returned as soon as possible.

_____ _____

Signature Date

_____ _____

Signature Date

Dr. John Carosso, Psy.D. & Associates, Inc.
Community Psychiatric Centers / Autism Center of Pittsburgh / Dyslexia Diagnostic & Treatment Center

INTAKE FORM

Client Information

Child's Name: _____

Date of Birth: _____ Age: _____ ___ Male ___ Female

Eye Color_____ Ethnicity:_____ Height: _____ Weight: _____

Address: _____

_____

County: _____

Who has physical custody of the child? _____

Who is Legal Guardian? ___ Parent ___ Other (specify)_____

Primary Parent/Guardian Contact Information

Home Landline Phone #: _____

Cell Phone #: _____

Email Address (please write legibly) _____

Neighborhood environment (please circle): rural / suburban / city / safe / unsafe (busy roads, etc…)

Primary Insurance (Commercial Ins.): _____ ID#: _____

Group # _____ Card Holder Name: _____

Card Holder Date of Birth: _____ (If other than child)

Secondary Insurance/Medicaid: _____ 10 Digit #: _____

Family Information

Mother's Name: _____ Age: _____

Specify (please circle): Biological / Adoptive / Foster / Legal Guardian / Other: _____

Place of Residence (if different):_____

Marital Status (please circle): Married; Divorced; Separated; Single; Never Married; Re-Married

Stepparent name (if applicable): _____

Father's Name: _____ Age: _____

Specify (please circle): Biological / Adoptive / Foster / Legal Guardian / Other: _____

Place of Residence (if different): _____

Marital Status (please circle): Married; Divorced; Separated; Single; Never Married; Re-Married

Stepparent name (if applicable): _____

Please list all those who live in the home with child:

Name	Age	Relationship	Special Needs
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Any siblings outside of the home and age:

_____/_____

_____/_____

_____/_____

Parent Occupation:

Mother/Guardian:_____

Father/Guardian:_____

Family's Religious Affiliation:_____

School Information

School: _____

School District: _____ Grade: _____

Special Education: ___ No ___ Yes

Type (please circle): Learning Support / Autism / Emotional Support / Other

Health / Medication / Mental Health

Any previous diagnoses?: __ No __ Yes

If Yes, please specify:

Current Medications:

Name	Dose
_____	_____
_____	_____
_____	_____

Past Medications:

Name	Reason discontinued
_____	_____
_____	_____
_____	_____

Who prescribes/ed the medication?: _____

Child's Pediatrician: _____

Pediatrician's Phone #: _____ Month/Year of Last Visit: _____

Review of Systems – Parent Checklist (Children & Teens)

General System
__ Recent weight changes
__ Notable fatigue or low energy
__ Unusually high energy
__ Frequent illnesses or fevers
__ Prolonged high fever
__ Serious medical conditions - if yes, please specify:
__ Visual deficits
__ Corrective lenses
__ Hearing deficits
__ Hearing aides
__ None of the above

Sleep System
__ Difficulty falling asleep
__ Difficulty staying asleep
__ Restless or poor-quality sleep
__ Nightmares
__ Snoring, or pauses in breathing
__ None of the above

Neurological System
__ Headaches or migraines
__ History of head injury or concussion
__ Loss of consciousness
__ Seizures or staring spells
__ Tics or tremors
__ Numbness or weakness
__ Problems with balance or coordination
__ None of the above

Cardiovascular / Respiratory System
__ Chest pain Heart racing or palpitations
__ Dizziness or fainting Shortness of breath or wheezing
__ None of the Above

Gastrointestinal System
__ Nausea or vomiting
__ Stomachaches
__ Constipation
__ Diarrhea
__ Appetite changes
__ None of the Above

Endocrine System
__ Heat or cold intolerance
__ Excessive thirst
__ Excessive urination
__ Menstrual irregularities (teens)
__ None of the Above

Musculoskeletal System
__ Joint pain
__ Muscle pain Weakness
__ Clumsiness or activity intolerance
__ None of the above

Dermatologic System
__ Rashes Eczema
__ Chronic skin concerns
__Hair pulling
__ Skin picking or scratching
__ None of the above

Immunological/ Allergy System
__ Allergies (food, environmental, medicine, latex). Please specify:
__ Asthma
__ Hives, swelling, itching
__ Any reactions requiring Benedryl, inhaler, or an EpiPen
__ Frequent infections (ear, strep, colds…)
__ None of the above

Has your child ever needed medical care or surgery for an illness or injury? (please circle): Yes / No
If yes, please describe:

Services

Any history of behavioral health services? (please circle): Yes / No
If yes, please specify type (outpatient counseling, wraparound/IBHS…):

Any current behavioral health services? (please circle): Yes / No
If yes, please specify type (outpatient counseling, wraparound…):

The agency's name providing the services: _____
Who referred your child for evaluation (person or agency)? : _____

CONCERNS *(Please checkmark those that apply)*

Family Instability / Trauma / Abuse

__ physical abuse
__ witness of domestic violence
__ foster care
__ neglect
__ parent incarceration
__ none of the above
__ sexual abuse
__ witness of parental substance abuse
__ out-of-home placement
__ children/youth services involvement

Any history of parental substance abuse? (please circle): Yes / No

Any history of domestic violence? (please circle): Yes / No

History of the child experiencing any trauma or abuse not listed above? (please circle): Yes / No

If Yes, please specify:

Signs of Autism

__ speech/language difficulties (limited vocabulary; talks in short phrases...)
__ not wanting to socialize
__ poor eye contact
__ hand-flapping
__ bouncing/hopping
__ toe-walking
__ spinning objects or themselves
__ obsessing on topics
__ not knowing how to socialize
__ lack of imagination/play skills (not knowing how to play)
__ rocking
__ echoing others (repeating)
__ lining-up of objects
__ fascination with objects and things (fans, trains, lights…)
__ repeating words and phrases from videos (scripting)
__ immediately repeating words of others (echoing others)
__ difficulty with changes in routine or unexpected events
__ extra-sensitive to clothing, sound, food, textures, light…
__ seems to seek sensory stimulation by bumping into things, wanting firm hugs…
__ restricted food preferences
__ none of the above

Behavioral Problems

__ defiance
__ back-talk
__ verbal aggression
__ attention problems
__ hyperactivity
__ difficult community behavior
__ tantrums
__ ignoring of direction
__ physical aggression
__ destruction of property
__ impulsivity
__ deficient grooming and hygiene
__tough time doing homework
__ none of the above

Emotional Problems

__ appears depressed
__ irritability
__ obsessive thoughts
__ sleep problems
__ self-injurious behavior
__ none of the above
__ anxiety
__ compulsions (doing things over and over)
__ low self-esteem
__ talk of wanting hurt self or not be alive
__ psychiatric hospitalization

Social Problems

__ difficulty establishing friendships
__ alienated by peers
__ withdraws from peers
__ social phobia (extreme fear of social situations)
__ none of the above
__ difficulty maintaining friendships
__ arguments with peers
__ physical confrontations with peers

School Problems

__ underachievement
__ behavior problems in school
__ after-school detentions
__ lunch/recess detentions
__ problems reading
__ problems writing
__ does not turn in homework
__ does not bring homework home
__ none of the above
__ school refusal
__ suspensions
__ threat of expulsion
__ poor grades
__ problems with math
__ leaves homework at home
__ being bullied

Food Issues

__ lack of appetite
__ over-eating
__ bingeing (eating large amounts of food in one sitting)
__ putting too much food in mouth at once food all at once
__ choking/gagging
__ can't sit through a meal
__ none of the above
__ finicky
__ an excessive time to eat meals
__ purging
__ low-calorie intake

Delinquency

__ problems with the police
__ alcohol use
__ cigarette use / vaping
__ probation
__ running away from home
__ marijuana / drug use
__ stealing from home/community (stores)
__ none of the above

Birth and Early Development

Any complications during pregnancy/delivery? (please circle): Yes / No

If Yes, please explain:

Any substances used during the pregnancy? (please circle): Yes / No

Full-term? (please circle): Yes / No Birth Weight: Pounds: ___ Ozs. ____

Born Healthy? (please circle): Yes / No Mom and Child discharged together? (please circle): Yes / No

Infant temperament: __ Calm and Pleasant __ Fussy

Any serious illnesses during infancy? (please circle): Yes / No

If Yes, please explain:

Developmental Milestones:

Walked independently by one year of age (please circle): Yes / No

Began expressing words and short phrases by two years of age (please circle): Yes / No

Toilet trained on time: Urination: (please circle): Yes / No Bowel Movements: (please circle): Yes / No

History of child being psychiatrically hospitalized? (please circle): Yes / No

If Yes, please specify:

Your child was how old when you first began to have concerns about their behavior?: ___

What were your first concerns?:

FAMILY MENTAL HEALTH HISTORY:
Please describe any past or current mental health issues on either side of the family (mother, father, brother(s), sister(s), grandparents, aunts, uncles, cousins), if diagnosed or even suspected:

STRENGTHS:
Please list some positive things about your child (examples: athletic, can be a good helper at times, good sense of humor, intelligent, inquisitive, friendly…):

NATURAL SUPPORTS:
Please list the *natural supports* for your child, which could include parents, grandparents on either side of the family, aunts, uncles, family friends, a church family, children's or youth pastor, coach, instructor, neighbors, teacher, guidance counselor, therapist…

STRENGTHS & RESILIENCY INVENTORY: SEARS

	Never / Sometimes / Often / Always			
Wants to help around the house……	0	1	2	3
Has an interest in other kids and wants to be around them……	0	1	2	3
Will approach and interact with other kids……	0	1	2	3
Other kids seem to think he/she is fun to be around……	0	1	2	3
Seems to understand the feelings of others……	0	1	2	3
Seems to care if he hurts somebody else's feelings……	0	1	2	3
Is able to problem-solve to make the situation better……	0	1	2	3
Is able to admit wrong-doing (to at least some extent)……	0	1	2	3
Is able to calm down quickly after becoming upset……	0	1	2	3
Is able to accept reasoning to calm down……	0	1	2	3

CHILD AND ADOLESCENT TRAUMA SCREEN-CAREGIVER (CATS-C) FORM

Name: _____

Stressful or scary events happen to many children. Below is a list of stressful and scary events that sometimes happen. Circle YES if it happened to your child to the best of your knowledge. Circle NO if it did not happen to the child.

1. Serious natural disaster like a flood, tornado, hurricane, earthquake, or fire…… yes no
2. Serious accident or injury like a car/bike crash, dog bite, or sports injury…… yes no
3. Robbed by threat, force, or weapon…… yes no
4. Slapped, punched, or beat up by someone in your family…… yes no
5. Slapped, punched, or beat up by someone not in your family…… yes no
6. Seeing someone in the family get slapped, punched, or beat up…… yes no
7. Seeing someone in the community get slapped, punched, or beat up…… yes no
8. Someone older touching their private parts when they shouldn't…… yes no
9. Someone forcing or pressuring sex when she/he/they couldn't say no…… yes no
10. Someone close to the child dying suddenly or violently…… yes no
11. Attacked, stabbed, shot, or hurt badly…… yes no
12. Seeing someone attacked, stabbed, shot, hurt badly, or killed…… yes no
13. Stressful or scary medical procedure…… yes no
14. Being around war…… yes no
15. Other stressful or scary event…… yes no

    Please describe:

CATS-C_Version 1.2 *Berliner & Goldbeck, 2014*

CONSENT TO ELECTRONIC TRANSMISSION Form

In an effort to be environmentally sensitive, we're offering the option of emailing you a password-protected and encrypted evaluation report, as opposed to mailing a hard copy. Along with the report, in an accompanying email, you'll be emailed a password to download the file.

Another benefit of an emailed digital file is that you'll receive the report days earlier compared to standard mailing.
Please indicate your consent by checking the box below:

☐ I consent to have a password-protected report emailed to me for my review.

My email address is:_____

☐ No, do not email me the report, I prefer a standard hard copy mailed to me.

Child's Name: _____

Parent's Name: _____

Parent Signature: _____

Date: _____

AUTHORIZATION FOR RELEASE OF INFORMATION Form

Patient's Name: _____

Date of Birth: _____

I hereby authorize Dr. John Carosso, Psy.D. & Associates, Inc. to release and/or exchange information regarding the above-named individual to the primary care physician listed below for the purpose of coordination of care, treatment planning, and continuity of services.

Primary Care Physician Name: _____

Name of PCP Practice: _____

Information to be Released:

☐ Psychological Evaluation Report

Purpose of Disclosure:

- Coordination of care
- Ongoing Treatment

Expiration of Authorization:

This authorization will remain valid for one (1) year from the date of signature below, unless revoked earlier in writing.

Revocation and Redisclosure Notice:

I understand that I may revoke this authorization at any time by providing written notice to Dr. Carosso's office. Revocation will not affect information already released prior to written notice. I also understand that once information is disclosed, it may be subject to redisclosure by the recipient and may no longer be protected by HIPAA.

Patient Signature (if over 14): _____

Parent/Guardian Signature (if under 14): _____

Printed Name: _____

Today's Date: _____

EPSDT PERIODIC SCREENING INFORMATION

Is your child/adolescent in need of their Periodic Screening?
The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT is designed to ensure that children and adolescents receive appropriate preventive, dental, mental health, developmental, and specialty services.

EPSDT includes:

Early - Assessing and identifying problems early
Periodic - Checking children's health at periodic, age-appropriate intervals
Screening - Providing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential concerns
Diagnostic - Performing diagnostic tests to follow up when a risk or concern is identified
Treatment - Providing services to control, correct, or reduce health problems that are discovered

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is a Medicaid benefit available to eligible children and adolescents under the age of 21.

If you have questions about the status of your child's screenings, please contact your child's Primary Care Provider (PCP/Pediatrician) or your Physical Health Managed Care Organization.

If you need help identifying your Physical Health Plan, you may contact Community Care at 866-668-4696.

Members enrolled with Carelon Behavioral Health may contact Carelon Member Services using the phone number listed on the back of their insurance card, or visit www.carelonbehavioralhealth.com for plan information, benefits, and assistance.

EPSDT SCREENING INFORMATION ACKNOWLEDGMENT

Client Name: _____
Date of Birth: _____

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services are preventive health services available for individuals under the age of 21. EPSDT services are designed to promote early identification, assessment, and treatment of physical, developmental, behavioral, and emotional health needs.

As part of the intake process, I have been provided with written information regarding EPSDT screenings **(see prior page**). I understand that EPSDT services include regular health screenings and any necessary diagnostic or treatment services identified through those screenings.

By signing below, I acknowledge that I have received and reviewed information regarding EPSDT screenings and understand that these services are available to my child/member.

Parent/Guardian (Printed): _____

Signature: _____

Date: _____