Contents of this file:

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.

Dr. John Carosso, Psy.D. & Associates, Inc.

Community Psychiatric Centers / Autism Center of Pittsburgh / Dyslexia Dx & Tx Center

CONSENT TO TREATMENT AND RELEASE OF REPORT

My signature below attests that I give consent to receive treatment/evaluation for my child, **from Dr. John Carosso, Psy.D**., Licensed Psychologist, and/or Dr. Carosso's Practice Associate from Dr. Carosso & Associates and/or Community Psychiatric Centers. I am seeking treatment with the intent of receiving the following:

Treatment/Assessment of / for my child _____

I have been informed that my child will be provided treatment/assessment for said presenting problem in accordance with ethical principles and research-based best practices. In this regard, an "evaluation" will consist of a clinical interview and possibly projective, intellectual, visual-motor, developmental, objective, and/or academic/intellectual assessment (drawings, inkblots, WRAT-4, Wechsler Scales, Developmental Inventory). Psychotherapy will consist of talk and possibly art, play, couples, and/or family therapy to address pertinent issues.

I am aware that treatment results are not guaranteed and that appropriate referrals will be provided, as needed. I have been informed that I can change clinicians, or end the therapy/evaluation, at any time.

I have been informed 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 a Certification in School Psychology. He also has 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 & Associates, PC**) is a partner at the mental health agency, **Community Psychiatric Centers**, Inc, and partner at the **Autism Center of Pittsburgh**.

Confidentiality and Release of Report

I have been informed that psychological services will be provided in an atmosphere of trust and, as such, all information will be kept confidential. However, with my signed consent below, the evaluation report containing clinical and personal information will be sent to relevant agencies including the referral source and the child's pediatrician. If treatment services are requested, my signature below reflects my permission to send the report to the local Base Service Unit and/or to the agency providing the service. I have been informed of the need to make Dr. Carosso, and/or a Practice Associate, aware of any specific pieces of information that I do not want included in the final report or if I do not want the report released. I have been offered a copy of my HIPAA privacy rights.

I have also been informed 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.

When my child is in therapy with Dr. Carosso or a Practice Associate, I have been informed that I will be provided periodic updates regarding my child's progress and recommendations while, at the same time, honoring my child's need for confidentiality. I give consent for Dr. Carosso to share written and verbal information regarding my child with Practice Associate and/or Community Psychiatric Centers staff.

Costs for Services

I have been informed of fee arrangements (insurance will be billed; out-of-pocket payment will be discussed and agreed upon prior to evaluation) and any relevant discounts. I give permission for Dr. John Carosso to bill my insurance company, and/or the funding source, and I understand that I am responsible to pay if the service is not covered by insurance, and/or the co-pay, that will be due at the end of the evaluation or at the end of each session.

Appointments and Emergencies

In regards to psychotherapy, I have been informed that the service will be provided at the time scheduled. I am aware of the importance of keeping the appointment in regards to maintaining the continuity and effectiveness of therapy and, if I cannot attend, to provide at least 24 hours' notice. In the case of emergencies, I have been informed that I can contact the Practice of Dr. Carosso, at any time, at 724-787-0497 or the following number(s):1-877-899-6500 or 412-372-8000. 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. I have also been informed of other emergency contact options such as the authorities (911).

_____	_____
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: _____

Eye Color_____ Ethnicity:_____ ___ Male ___ Female

Height (if known): _____ Weight (if known): _____

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…)

Family's Religious Affiliation:_____

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

Biological Mother's Name: _____ Age: _____

Place of Residence (if different):_____

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

Stepparent name (if applicable): _____

Biological Father's Name: _____ Age: _____

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
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Parent Occupation:

Mother/Guardian:_____

Father/Guardian:_____

Any siblings outside of the home and age:

_____/_____

_____/_____

_____/_____

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: _____

Pediatricians Phone #: _____ Month/Year of Last Visit: _____

Medical Conditions (please check all that apply):

__ Allergies Type?:
__ Asthma
__ Hearing deficits (hearing aide?):
__ Serious medical conditions
__ Loss of consciousness
__ Seizures
__ Vision deficits (glasses?):
__ Head Trauma
__ Prolonged high fever

Has your child ever needed medical care or surgery for an illness or injury? (please circle): Yes / No
If so 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
___ Sexual Abuse
___ Witness of parental substance abuse
___ Out of home placement
___ Children-Youth services involvement

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

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

Emotional Problems

__Appears depressed
__Irritability
__Obsessive thoughts
__Sleep problems
__ Self-Injurious behavior
__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
__ Difficulty maintaining friendships
__Arguments with peers
__Physical confrontations with peers
__Social phobia (extreme fear of social situations)

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
__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
__ Finicky
__ 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)

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

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

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

History of child experiencing any trauma or abuse? (please circle): Yes / No

If Yes, please specify:

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 his/her 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

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: _____