Hello From Dr. John Carosso, Child Psychologist

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Greeting and Introductory Information

Welcome 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 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 more information about your child's history and current functioning.
- Please bring your child to the evaluation, and child's insurance card.
- Feel free to bring any prior reports or behavioral forms.
- Please call Mr. John Delmonte, my billing specialist, prior to the apt, so that any necessary pre-certification and insurance issues can be processed. John can be reached at 1-888-924-3627 or email at john.dmbs@gmail.com

- Many of my offices have a fully stocked playroom, but your child may not feel comfortable remaining in the play area without you present with them. Consequently, it may be best to have a spouse, friend, or relative accompany you to watch your child while we talk privately in the evaluation room. In that respect, understandably, some children become fussy when grown-ups are talking about them in their presence, especially when the information being presented is not particularly flattering. However, if you do not have anyone to accompany you, that's okay; we'll work around that and help your child to feel comfortable that can include remaining with you throughout the entirety of the evaluation.

- After confidentially speaking with you to obtain information your child, I'll spend time with your child and, thereafter, we'll then talk to discuss my formulation, recommendations, and a thorough 'game-plan', and then conclude the evaluation session. Thereafter, you'll receive a comprehensive report.

- If your child is already receiving wraparound services, feel free to invite the Behavioral Specialist 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 website/blog at helpforyourchild.com where you can see my video-blog ("*Dr. C's Morning Minute")* including a video that describes the ***Evaluation Process***.

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

Please scroll down to find **the Consent to Treatment** form

Please sign the consent form and bring with you to the evaluation

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 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 the 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

Please scroll down to find the **Intake Form** (Please complete the intake and bring with you to the evaluation – Thank you)

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

Community Psychiatric Centers / Autism Center of Pittsburgh
Dyslexia Diagnostic & Treatment Center

Client Information

Child's Name: _____
Date of Birth: _____
Age: _____ _____ **Male** _____ **Female**

Eye Color _____ **Ethnicity:** _____
Height (if known): _____ **Weight (if known):** _____

Address:

_____

_____

County: _____

Home Phone Number: _____
Alternative (cell) # _____

Email Address (parent): _____
Neighborhood environment: rural / suburban / city / safe / unsafe /

Insurance: **Primary** _____ ID # _____
Grp # _____
Card Holder Name _____ Card Holder Date of Birth: _____
(If other than child)

Secondary Insurance (Medical Assistance) _____ **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) _____

Who has physical custody of the child? _____
Legal Guardianship: _____

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

Name	Age	Relationship/Special Needs?
_____		_____
_____		_____
_____		_____
_____		_____
_____		_____

Parent Occupation:

Mother/Guardian:_____

Father/Guardian:_____

Family's Religious Affiliation:_____

Any siblings outside of the home and age:

_____

_____

_____

<u>School Information</u>

School: _____

School District: _____

Grade: _____

Special Education: _____ No ___ Yes: Type: Learning Support / Autism
Emotional Support / Other

<u>Health / Medication / Mental Health</u>

Any previous diagnoses?: ___ No ___ Yes. Please specify:_____

_____

_____

<u>Current Medications</u>:

Name	Dose
_____	_____
_____	_____
_____	_____

Past Medications:

Name	Reason discontinued
_____	_____
_____	_____
_____	_____

Who prescribes the medication:_____

Child's Pediatrician: _____

Pediatricians Phone # _____ Month/Year of Last Visit _____

Medical Conditions

Allergies	**___ No**	**___ Yes: Type-**
Asthma	**___ No**	**___ Yes**
Seizures	**___ No**	**___ Yes**
Hearing deficits (hearing aide?)	**___ No**	**___ Yes**
Vision deficits (glasses?)	**___ No**	**___ Yes**
Serious medical conditions?	**___ No**	**___ Yes**
Head Trauma	**___ No**	**___ Yes**
Loss of consciousness	**___ No**	**___ Yes**
Prolonged high fever?	**___ No**	**___ Yes**

Has your child ever needed medical care or surgery for an illness or injury?
Yes / No
If so please describe:_____

Services

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

Any current behavioral health services? _____ No _____ Yes
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 check-mark 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
__ Not knowing how to socialize
__ Poor eye contact
__ Lack of imagination/play skills (not knowing how to play)

Odd Behaviors:

___ hand-flapping
___ rocking
___ bouncing/hopping
___ echoing others (repeating)
___ toe-walking
___ lining-up of objects
___ spinning objects or themselves
___ fascination with moving objects (fans, trains…)
___ obsessing on topics
___ 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
__ Difficulty maintaining friendships
__Arguments with peers
__Physical confrontations with peers
__Alienated by peers
__Withdraws from 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 amts of once food all at once)
__Purging
__Low calorie intake
___ Finicky
___ Excessive time to eat meals
___ Putting too much food in mouth at
___ Choking/Gagging
___ Can't sit through a meal

Delinquency

__Problems with the police
__Alcohol use
__Cigarette use
__ Probation
__Running away from home
__Marijuana use
__ Stealing from home/community (stores)

Birth and Early Development

Any complications during pregnancy/delivery: No _____
Yes _____ If Yes, please explain:

Any substances used during the pregnancy? ___ Yes ___ No

Full-term: Yes / No

Birth Wt: Pounds: ___ ozs. _____ Born Healthy: Yes / No:

Mom and Child discharged together: Yes / No

Infant temperament: _____ Calm and Pleasant; _____ Fussy

Any serious illnesses during infancy? ___ Yes ___ No If so please explain:

_____

_____

Developmental Milestones

Walked independently by one year of age: Yes / No

Began expressing words and short phrases by two years of age: Yes / No

Toilet trained on time: N/A Urination: Yes / No Bowel Movements: Yes / No

Any history of parental substance abuse? ___ Yes ___ No

Any history of domestic violence? ___ Yes ___ No

History of child experiencing any trauma or abuse (N / Y) Specify:

History of child being psychiatrically hospitalized (N / Y)

Your child was how old when you first began to have concerns about his/her behavior:

What were your first concerns?

Please describe any ***family history of behavioral health*** issues (either side of the family including mother, father, brother(s), sister(s), grandparents, aunts, uncles, cousins…?

STRENGTHS / SUPPORTS

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

Please list some family strengths and supports (examples: extended family including grandparents, church family, family friends, Case manager, Counselor, Big Brother or Sister, Boy or Girl Scouts, other community agencies…)

___ Grandparents
___ Aunts/Uncles/cousins
___ Church family
___ family friends
___ Counselor
___ Sports
___ Big Brother or Sister
___ Boy or Girl Scouts
___ Dance classes
___ Case manager

Strengths and Resiliency Inventory: SEARS

Please complete this section if your child is age 3 to 6 years of age

	Never	Sometimes	Often	Always
Wants to be a helper 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 play 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
Solves simple problems 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

Please complete this section if your child is age 7 through Teenage years:

	NEVER	SOMETIMES	OFTEN	ALWAYS
Tries to help others when they need help……..	0	1	2	3
Makes friends easily…….	0	1	2	3
Other kids ask him/her to hang out with them……	0	1	2	3
People think she/he is fun to be with……..	0	1	2	3
Understands how other people feel……	0	1	2	3
Cares what happens to other people……..	0	1	2	3
Thinks of her/his problems in ways that help…….	0	1	2	3
Accepts responsibility when she/he needs to……	0	1	2	3
Is able to handle problems on her/his own……..	0	1	2	3
Knows how to calm down when stressed or upset…….	0	1	2	3
Knows how to identify and change negative thoughts…….	0	1	2	3
Can identify errors in the way he/she thinks about things……	0	1	2	3

Behavioral Assessment - Progress Tracker (BA-PT)

Please *circle the number* to indicate the extent of difficulty in each area:

Your child's mood

Happy……Neutral……..……Irritable/Depressed

1 2 3 4 5 6 7 8 9 10

Anger / Outbursts

Stable……Some outbursts……..……..……Explosive

1 2 3 4 5 6 7 8 9 10

Following Directions / Defiance

Complies… Ignores… Put's it off but does it… Oppositional (some back-talk)… Outright Defiant

1 2 3 4 5 6 7 8 9 10

Response to Discipline (such as being sent to time-out or loss of video-game)

Accepts the punishment without problem……Whines……..Cries……..…Yells……..Hits, Kicks

1 2 3 4 5 6 7 8 9 10

Attention to Task

Good Attention……..……..…..Completes short tasks……..…Needs "constant prompting

1 2 3 4 5 6 7 8 9 10

Activity Level / Hyperactive

Able to remain focused……..Fidgety……..……..….Can't sit still

1 2 3 4 5 6 7 8 9 10

Ability to Occupy Free-Time Appropriately

Able to occupy time without problem……. Always into mischief - have to watch very closely

1 2 3 4 5 6 7 8 9 10

Sleep and Bedtime Behavior

Sleeps well…….. Up a few times……Up throughout night or can't/won't fall asleep

1 2 3 4 5 6 7 8 9 10

Appetite and Mealtime behavior

Eat well ……..….Finicky but eats relatively well……Won't eat or very finicky

1 2 3 4 5 6 7 8 9 10

Grooming/Hygiene and Morning/Bedtime Routine

No Problem……..……..Will bathe if prompted……Refuses to bathe or doesn't care

1 2 3 4 5 6 7 8 9 10

Friendships / Socialization

No Problem……..……Some friends (only a few and has difficulties with this)……..……No Friends

1 2 3 4 5 6 7 8 9 10

Sibling Relationship

Generally get along……Bicker a lot……Fight a lot and Physically Aggressive

1 2 3 4 5 6 7 8 9 10

Community Behavior

Generally okay……..Some Problems……..All over the place and tantrums
1 2 3 4 5 6 7 8 9 10

School Behavior/Functioning

Functions pretty well……..……Some conflicts and Difficulties……Fights and Suspensions

1 2 3 4 5 6 7 8 9 10

AUTISM

Self-Stimulatory Behavior

Rare…….....Sometimes (easily redirected)……..……Frequent 'stims' (hand-flapping, rocking…)

1 2 3 4 5 6 7 8 9 10

Communication / Verbal Skills

Very Verbal……Moderate Problems…… Very Limited (nonverbal or echo/script)

1 2 3 4 5 6 7 8 9 10

Obsessions

Not obsessive……...Moderate……...Severe (always talking about the same thing)

1 2 3 4 5 6 7 8 9 10

Sensory

No major problems……Lots of Sensory issues (gets in the way of daily functioning)

1 2 3 4 5 6 7 8 9 10

Dr. John Carosso & Associates, Inc.

We're Going Green!!!

In an effort to be environmentally sensitive, we're 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 when compared to standard mailing.

Please indicate your consent below:

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

My email address is:_____

_____

- o 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:_____