STEEL COUNSELING, PLLC
Ann H. Steel. MD, MA, LMHC
206-707-1683
Mental Health Counselor License # LH 60352590

Parent Evaluation of Child

NAME: _____CHILD's NAME: _____Date: _____

What are your concerns about your child's technology use?

What have you/they tried so far to work on these issues?

Please list the **type** of technology your child used (laptop, Xbox/consoles, TV, cell phone etc.) and **time** spent
Age 0 to 2

Age 2 to 5

Age 5 to 10

Middle School

High School

Current Use:

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Please list any Medical Illnesses/Surgeries/Head Injuries:

Current Medications:

Past Medications tried:

Does your child have any mental health diagnoses?

Past therapists or psychiatrists:

Is there any family history of mental health disorders or addictions?:

Has your child suffered any traumas?

Does your child have a history of violence or access to weapons?

Has your child been suicidal or homicidal history or have any history of self-harm/cutting?

Drug use, alcohol use, prescription drug abuse, nicotine, caffeine:

Any attempts to run away?

School truancy issues: