



Meaningful Directions Therapeutic Services, LLC.

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Meaningful
Directions

APPLICATION

Date: _____

Legal Name: _____ Date of Birth: _____ Age: _____

Name: _____ Pronouns: _____

Parent/Guardian: _____

Address: _____

Telephone: _____ Email: _____

Household Composition:

Name:	Age	Relation to client

Reason for Visit: _____

Previous Counseling Experience: _____

Current Diagnosis: _____

Current Medical Issues/Concerns: _____

Current Medications: _____ Dosage: _____ Prescribed by: _____

Allergies: _____

Biological Sex: Female: _____ Male: _____ Intersex/DSD: _____

Gender Identity: _____

Sexual Orientation: _____

Is religion, faith, or spirituality important in your life: _____

If so, what religion or spirituality do you follow: _____

History of:

	Yes	No
ADHD		
Adoption or Foster Child		
Alcoholism		
Anxiety		
Assaultive/Aggressive Behaviors		
Autism/Asperger's		
Depression		
Delivery Complications		
Family Stresses (Separation/Divorce, Relocation, Financial)		
Medical/Delivery complications		
Neurological Problems		
Physical/Sexual Abuse		
Speech or Language Delays		
Substance Abuse		

Employer Name & Address: _____

Full Time _____ Part Time _____ Unemployed _____

School Name & Address (for child): _____

Child Study Team Evaluation: No _____ Yes _____ When? _____

Teacher's or School Counselor's Name: _____

Tell me about yourself/your child:

Strengths? _____

Weaknesses? _____

How did you hear about us? _____