



# Sidran Institute

TRAUMATIC STRESS EDUCATION & ADVOCACY

## Support and Therapy Groups for Sidran Resource Database

If you run psychotherapy or processing groups for people who have experienced psychological trauma, childhood abuse, or dissociation, the Sidran Institute would like to list them in our Trauma Resources Database. To be included, please complete the questionnaire below. There is no charge for inclusion, and we thank you for the work that you do. If you need more space for any of the questions, please feel free to attach an additional sheet. Please mail completed form to 7220 Muncaster Mill Rd Suite 376 Derwood, MD 20855, or fax the form to us at 410-825-8888, or email to [help@sidran.org](mailto:help@sidran.org). Thank You.

### **Contact Information:** (\* required information)

\*Name of group: \_\_\_\_\_

\*Your Name: \_\_\_\_\_

\*Degree(s): \_\_\_\_\_

Website: \_\_\_\_\_

Company: \_\_\_\_\_

Title: \_\_\_\_\_

\*Office Address: \_\_\_\_\_

\*City: \_\_\_\_\_ \*State: \_\_\_\_\_

\*Zip Code: \_\_\_\_\_ \*Country: \_\_\_\_\_

\*Phone Number: \_\_\_\_\_ Extension: \_\_\_\_\_

Alternate Phone Number: \_\_\_\_\_ Extension: \_\_\_\_\_

Fax Number: \_\_\_\_\_ Therapist Gender: \_\_\_\_\_

\*Email (for Administrative Use Only): \_\_\_\_\_

Public Email (optional): \_\_\_\_\_

Do you give Sidran permission to share your public email with potential clients? Yes \_\_\_ No \_\_\_

\*Have you previously submitted your information? Yes \_\_\_ No \_\_\_

Intake/Contact Person: \_\_\_\_\_

Philosophical Orientation (spiritual/religious): \_\_\_\_\_

\*Please describe the support/therapy group: \_\_\_\_\_

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Briefly state your treatment philosophy. What issues does your program focus on and how do you treat them?: \_\_\_\_\_

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**Training and Credentials:**

\*Please list experience, including credentials, for running this therapy group. Please include degrees, certification, and other training: \_\_\_\_\_

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\*Please list memberships in professional organizations: \_\_\_\_\_

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\* Have you ever been censured by any professional licensing body? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, please specify dates and circumstances: \_\_\_\_\_

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\* Do you have advanced training in trauma/PTSD? Yes  No

Please specify training: \_\_\_\_\_

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\*How many years of experience do you have treating trauma/PTSD? \_\_\_\_\_

\*Please describe more about your experience in treating trauma/PTSD: \_\_\_\_\_

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\* Do you have advanced training dissociative disorders/DID? Yes  No

Please specify training: \_\_\_\_\_

\_\_\_\_\_

\*How many years of experience do you have treating DID? \_\_\_\_\_

\*Please describe more about your experience in treating DID: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\* Are you affiliated with a hospital or medical center? Yes  No

If yes, please name the institution and describe the relationship: \_\_\_\_\_

\_\_\_\_\_

### **Populations Served:**

\*Populations served: Children? Adolescents? Adult Men? Adult Women?

\* Is your office accessible to people with physical disabilities? Yes  No

\*Do you treat:

Post Traumatic Stress Disorder?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Dissociative Disorders?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Dissociative Identity Disorder?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Ritual abuse/Mind control?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Borderline Personality Disorder?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Sleep Disorders?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Depressive Disorders?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Anxiety Disorders?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Eating Disorders?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Self-Injury?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Substance Abuse/Dual Diagnosis?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Sexual Orientation/Identity Issues?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Combat Trauma?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Other Relevant Specialties (Please Describe): \_\_\_\_\_

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**Insurance Information:**

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|---|------------------------------|-----------------------------|
| *Do you have/accept: Private Insurance? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Medicare?                               | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| State Assistance?                       | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Financial Assistance?                   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| A Sliding Fee Scale?                    | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Payment Plans?                          | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

Please specify which insurance plans you accept: \_\_\_\_\_

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