



Sidran Institute

TRAUMATIC STRESS EDUCATION & ADVOCACY

Therapist Form for Sidran Resource Database

If you are a clinician treating clients who have experienced psychological trauma, childhood abuse or dissociation, the Sidran Institute Help Desk would like to list your services in our resources database. To be included in our Therapist Directory, please complete the questionnaire below. If you need more space for any of the questions, please feel free to attach an additional sheet. There is no charge for inclusion. 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. Thank You.

Contact Information: (* required information)

*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 ___

Training and Credentials:

*Please list degrees, certification, and other training: _____

*Please list memberships in professional organizations: _____

* Have you ever been censured by any professional licensing body? Yes _____ No _____

If yes, please specify dates and circumstances: _____

*Do you use: hypnosis? EMDR? Energy Therapies? Somatic Therapy?
Expressive Therapies?

Please describe and specify for what purposes: _____

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

Please specify training: _____

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

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

* 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: _____

Services Provided:

*Do you provide: Individual Therapy? Yes No
 Group Therapy? Yes No
 Family Therapy? Yes No
 Couples Therapy? Yes No
 Therapist-Run Support Groups? Yes No

* Are you affiliated with a treatment center that provides inpatient services? Yes No

* Are you affiliated with a psychiatrist that provides pharmaceutical support? Yes No

Populations Served:

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

*Special Populations served:

Gay/Lesbian? Combat Veterans? Refugees? Ritual Abuse Victims?

Offenders (Adult)? Offenders (Juvenile)?

*Please specify experience with these special populations: _____

Please describe any other special populations that you serve: _____

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

*Are you fluent in any languages other than English (including ASL for the hearing impaired)? If so, please specify which ones: _____

*Do you provide online counseling via secure web-based software? Yes No

If so, please describe: _____

*Do you provide counseling over the phone? Yes No

If so, please describe: _____

*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): _____

Insurance Information:

*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"/>
Negotiable Fees?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
A Sliding Fee Scale?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Fee only (no insurance)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Please specify which insurance plans you accept: _____
