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 7238 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 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: _____

_____

_____

_____

_____

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

Training and Credentials:

*Please list experience, including credentials, for running this therapy group. Please include 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 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:_____

_____

_____

_____

* 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 ☐	No ☐
Dissociative Disorders?	Yes ☐	No ☐
Dissociative Identity Disorder?	Yes ☐	No ☐
Ritual abuse/Mind control?	Yes ☐	No ☐
Borderline Personality Disorder?	Yes ☐	No ☐
Sleep Disorders?	Yes ☐	No ☐
Depressive Disorders?	Yes ☐	No ☐
Anxiety Disorders?	Yes ☐	No ☐
Eating Disorders?	Yes ☐	No ☐
Self-Injury?	Yes ☐	No ☐
Substance Abuse/Dual Diagnosis?	Yes ☐	No ☐
Sexual Orientation/Identity Issues?	Yes ☐	No ☐
Combat Trauma?	Yes ☐	No ☐

Other Relevant Specialties (Please Describe):_____

_____

_____

Insurance Information:

*Do you have/accept:	Private Insurance?	Yes ☐	No	☐
	Medicare?	Yes ☐	No	☐
	State Assistance?	Yes ☐	No	☐
	Financial Assistance?	Yes ☐	No	☐
	A Sliding Fee Scale?	Yes ☐	No	☐
	Payment Plans?	Yes ☐	No	☐

Please specify which insurance plans you accept: _____

_____

_____

_____