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:**

* 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:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________