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 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: ____________________________________________________________
*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: ________________________________
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Please describe and specify for what purposes: ________________________________
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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: ________________________________
_____________________________________________________________________________
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* 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:


*Special Populations served:
  Offenders (Adult)?□  Offenders (Juvenile)?□
*Please specify experience with these special populations: ______________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
Please describe any other special populations that you serve: __________________________
___________________________________________________________________________
___________________________________________________________________________
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* 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:

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<thead>
<tr>
<th>Disorder</th>
<th>Yes □</th>
<th>No □</th>
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<tbody>
<tr>
<td>Post Traumatic Stress Disorder?</td>
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<td>Dissociative Disorders?</td>
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<td>Dissociative Identity Disorder?</td>
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<td>Ritual abuse/Mind control?</td>
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<td>Borderline Personality Disorder?</td>
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<td>Sleep Disorders?</td>
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<td>Depressive Disorders?</td>
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<td>Anxiety Disorders?</td>
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<td>Eating Disorders?</td>
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<td>Self-Injury?</td>
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<td>Substance Abuse/Dual Diagnosis?</td>
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<td>Sexual Orientation/Identity Issues?</td>
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<td>Combat Trauma?</td>
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Other Relevant Specialties (Please Describe): ____________________________________________

**Insurance Information:**

*Do you have/accept: Private Insurance? Y □ N □
Medicare? Y □ N □
State Assistance? Y □ N □
Negotiable Fees? Y □ N □
A Sliding Fee Scale? Y □ N □
Fee only (no insurance)? Y □ N □

Please specify which insurance plans you accept: _______________________________________

_________________________________________________________________________________
**Therapist Statement:**

* Write something about yourself or your practice that potential clients would benefit from knowing: this could include your approach, philosophy, background, techniques or other information. This statement will be shared with prospective clients (Please attach an additional sheet, if needed):

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