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 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: _______________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

*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 ☐ | 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 ☐ |
| Negotiable Fees? | Yes ☐ | No ☐ |
| A Sliding Fee Scale? | Yes ☐ | No ☐ |
| Fee only (no insurance)? | Yes ☐ | No ☐ |

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):