PROVIDER NAME:_____ DATE:_____

LANGUAGES YOU CAN TREAT IN FLUENTLY:	**PROVIDERS ETHNICITY:**
☐ English ☐ Spanish ☐ French ☐ ASL (American Sign Language) ☐ Other: *(please write below)* _____ _____ _____	**DO YOU HAVE LIMITATIONS IN YOUR PRACTICE?** _____ _____ **WHAT IS YOUR PRACTICE PROFILE FOCUS?** _____ _____ _____

SPECIALTIES (check all that apply)

☐ ADD/ADHD	☐ DIALECTIC BEHAVIORAL THERAPY-DBT	☐ NEUROPSYCH TESTING
☐ ADJUSTMENT TO ILLNESS/DISABILITY	☐ DISSOCIATIVE DISORDERS	☐ OBSESSIVE-COMPULSIVE-OCD
☐ ADOPTION	☐ DOMESTIC VIOLENCE	☐ OCCUPATIONAL ISSUES
☐ ANGER MANAGEMENT	☐ DUAL DIAGNOSIS	☐ OUTPATIENT DETOXIFICATION
☐ ANXIETY	☐ EATING DISORDERS	☐ PAIN MANAGEMENT
☐ APPLIED BEHAVIORAL ANALISIS-ABA	☐ EMDR	☐ PARENTING ISSUES
☐ AUTISM SPECTRUM DISORDER	☐ FAMILY THERAPY	☐ PERSONALITY DISORDERS
☐ BIOFEEDBACK	☐ GAMBLING	☐ PHARMACOLOGY-MED MGMT
☐ BIPOLAR	☐ GAY-LESBIAN	☐ PLAY THERAPY
☐ CERTIFIED EAP	☐ GENDER IDENTITY	☐ POST TRAUMATIC STRESS-PTSD
☐ CHEMICAL DEPENDENCY	☐ GERIATRIC PSYCHIATRY	☐ PSYCHOLOGICAL TESTING
☐ CHILD ABUSE	☐ GRIEF COUNSELING	☐ PSYCHOTIC DISORDERS
☐ CHRISTIAN COUNSELING	☐ GROUP THERAPY	☐ SAP
☐ CHRONIC PAIN	☐ HEARING IMPAIRED	☐ SELF MUTILATION
☐ CISD	☐ HIV/AIDS	☐ SEXUAL ADDICTION
☐ CODEPENDENCY	☐ HYPNOTHERAPY	☐ SEXUAL DYSFUNCTION
☐ COGNITIVE BEHAVIORAL THERAPY-CBT	☐ IN HOME THERAPY	☐ SEXUAL-PHYSICAL ABUSE
☐ COMORBIDITY	☐ LEARNING DISABILITIES	☐ STRESS MANAGEMENT
☐ COUPLES COUNSELING	☐ LIFE MANAGEMENT COUNSELING	☐ TERMINAL ILLNESS
☐ CRISIS INTERVENTION	☐ MANAGED DISABILITY	☐ TRAUMATIC BRAIN INJURY-TBI
☐ CULTURAL DIVERSITY	☐ MEN'S ISSUES	☐ WOMEN'S ISSUES
☐ DEPRESSION	☐ MOOD DISORDERS	☐ MINDFULNESS THERAPY

CULTURALLY DIVERSE SPECIALITIES:_____

AGE PREFERENCE: Put ages for each. _____Child _____ Adolescent _____Adult _____ Geriatric

PRACTICE HOURS: Sun____Mon_____Tues_____Weds_____Thurs_____Fri_____Sat_____

DOES YOUR PRACTICE MEET ALL ADA REQUIREMENTS: **YES**☐ **NO**☐

HOW FAR AWAY IS YOUR PRACTICE FROM PUBLIC TRANSPORTATION:_____ miles/ block

HAVE YOU COMPLETED CULTURAL COMPETENCY TRAINING? YES☐ **NO**☐

DO YOU HAVE HOSPITALS AFFILIATIONS? YES☐ **NO**☐ **NAME/CITY of HOSP:**_____

DO YOU HAVE AN ARRANGEMENT WITH A PROVIDER FOR ADMITTING YOUR PATIENTS? YES☐ NO☐

IF SO, PLEASE GIVE DETAILS:_____

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