



Mental Health Provider QUESTIONNAIRE

1. How would you describe your profession? Please check all that apply:

- Counselor
- Educational Therapist
- Psychiatric Nurse
- Psychiatrist
- Psychologist
- Psychotherapist
- Therapist
- Other _____

2. Where did you train? (college, years, and length of supervised training.)

Please check your degrees below:

- ABPP
- ACSW
- ARNP
- CCMHC
- CPP
- CMHS
- LCSW
- LICSW
- LMFT
- LMHC
- LMT
- MA
- MEd
- MFT
- MPS
- MS
- MSW
- MSC
- NNC
- PhD
- PsyD
- RN
- Other _____

How long have you held your license/certification?

3. Please check all of your specialties and note your basis for the specialty:

- Abuse
- ACOA
- ADD/ ADHD
- Addiction
- Adjustment Disorders
- Anger Management
- Anxiety
- Asberger's
- Autism
- Behavior Problems
- Bipolar
- Chemical Dependency
- Communication Skills
- Conduct Disorder
- Cultural Issues
- DBT
- Death
- Depression
- Developmental Delays
- Dissociative Disorder
- Eating Disorders
- EMPR
- Family Transitions
- Grief
- Health Issues
- Insomnia
- Learning Disabilities
- Mood Disorders
- OCD
- Phobias
- PTSD
- Schizophrenia
- Sexual Abuse
- Sex/Gender Issues
- Stress Management
- Substance Abuse
- Suicidality
- Tourette's Syndrome
- Trauma
- Other _____



4. What sort of evaluation and treatment services do you offer? Please check all that apply:

- Biofeedback
- Cognitive Behavioral Therapy
- Developmental Evaluations
- Exposure Therapy
- Hypnosis
- Medication Management
- Neuropsych Evaluations
- Play Therapy
- Psychological Evaluations
- Relaxation
- Solution Focused Therapy
- Somatic Experiencing
- Thought Field Therapy
- Other _____

5. Do you treat Children and/or Teen-Agers? Yes _____ No _____

If Yes, Age Range:

6. Do you speak a language other than English. If yes which language(s)?

7. Is your practice open to new patients? If so, how long is the waiting period?

8. Which private insurances do you accept?

9. Do you accept Medicaid?

10. Do you offer a sliding scale for uninsured youth? If so, what are the rates?

11. Are you interested in joining the Whatcom County TeenScreen effort? If so, in what capacity (attending monthly meetings, volunteering in schools to review Screening Summary forms, accepting referrals based on TeenScreen screening results, other)?

Name: _____

Phone Number: _____

Email Address: _____

Address: _____

Hours of Operation:

M T W T H F S S

mornings afternoons evenings