PROVIDER PROFILE

Provider Name: _____

DOB:_____/_____/_____ Year licensed:_____

Name of graduate school: _____ Year graduated: _____

Please check the following treatment populations that you are able to teat and include an 'S' if you have specialized training.

**Please be advised, your identified areas of experience on this form will be used as an aid in referrals to you and will be posted on the website. **

Age Group*

_____ Children {Ages ___ to___}

_____ Adolescent

_____ Adult

_____ Geriatric

Languages*

_____ Sign Language

_____ Other language fluently spoken beside English:

_____

Techniques*

_____ Cognitive Therapy

_____ Couples Therapy

_____ DBT (Dialectical Behavioral Therapy)

_____ EFT (Emotionally Focused Therapy)

_____ Family Counseling

_____ Play Therapy

Techniques requiring Management Authorization*

_____ EMDR (Eye Movement Desensitization & Reprocessing)

_____ Hypnotherapy

_____ Psych Testing

Specialties*

_____ Adoption Issues

_____ Autism

_____ ADHD/ADD (Attention Deficit/ Hyperactivity Disorder)

_____ Adults abused/molested as children

_____ Adult/ children of Alcoholics

_____ Anger Management

_____ Anxiety/Stress Mgt.

_____ Bariatric

_____ Bipolar Disorder

_____ Chemical Dependency

_____ Child Abuse/Molestation

_____ Christian Focus

_____ Chronic Fatigue Syndrome

_____ Chronic/Terminal Illness

_____ Crisis Intervention

_____ Disability

_____ Divorce

_____ Domestic Violence

_____ Gay/Lesbian Issues

_____ Grief/Loss

_____ Infertility

_____ Learning Disabilities

_____ Minority Issues Specify:

_____

_____ Multiple Personality

_____ Obsessive Compulsive Disorder

_____ Panic Disorders

_____ Pervasive Developmental Disorders

_____ Phobias

_____ Post-Partum

_____ PTSD (Post Traumatic Stress Disorder)

_____ Schizophrenia

_____ School Violence

_____ Selective Mutism

_____ Sexual Compulsive Behavior

_____ Sexual Dysfunction

_____ Sports Psychology

_____ Step/Blended Families

_____ Tourette's syndrome

_____ Knowledge in 12-Step

_____ Other (Specify):

PROVIDER PROFILE

This information is given to PsyCare office staff to be used as an aid in referrals.

License #: _____ DEA# (MDs Only): _____

Date Licensed: ____/____/____ Date of Hire: ____/____/____

Gender: Male Female Date of Birth: ____/____/____

General Provider Information (okay to disclose to patients):

_____

_____

Provider profile for exceptional psychiatric conditions.

1. Would you accept treating a patient who suffers from:

   a. Autism Spectrum Disorder - Y N

   b. Dementia - Y N

   c. Eating Disorder(s) - Y N Specify: _____

   d. Encopresis/Enuresis - Y N

   e. Gender Identity Issues - Y N

   f. HIV/AIDS (provided diagnosis disclosed by patient) - Y N

   g. PTSD (combat related) - Y N

   h. PTSD (noncombat related) - Y N

   i. Traumatic Brain Injury/Severe neurologic conditions - Y N

   j. Trichotillomania - Y N

   k. Other _____ - Y N

2. Would you accept treating a patient who suffers from substance use disorder and is willing to cut back use, agree to level of care recommended (i.e., inpatient/detox/partial hospitalization program/IOP/rehab-sober living/AA/NA/smart recovery/other _____) and commit to abstinence for the substance/s:

   a. Alcohol - Y N

   b. Opiates - Y N

   c. Benzodiazepine/sedative hypnotics - Y N

   d. Stimulants (i.e., cocaine, amphetamine) - Y N

   e. Marijuana (“medical card” or recreational) - Y N

   f. Other _____ - Y N