



MENTAL HEALTH PROFESSIONAL INFORMATION SHEET

(PLEASE PRINT OR TYPE)

NAME: _____

PLEASE CHECK ONE: MD PhD MSW LPC LCSW OTHER: _____

PRACTICE NAME: _____

OFFICE ADDRESS: _____

PHONE: _____ **FAX:** _____ **EMAIL:** _____

EDUCATIONAL BACKGROUND: _____

LICENSES AND CERTIFICATIONS: _____
(please include copies of certifications)

PROFESSIONAL ASSOCIATIONS TO WHICH YOU BELONG: _____

TREATMENT MODALITIES USED (cognitive, psychoanalytical, biofeedback, specialty psychoeducational groups, etc.):

CURRENTLY ACCEPTING NEW PATIENTS? YES NO

CLIENTELE SERVED *(check all that apply):*

- | | | |
|-----------------------------------|--------------------------------------|-----------------------------------|
| <input type="checkbox"/> CHILDREN | <input type="checkbox"/> ELDERLY | <input type="checkbox"/> ADULTS |
| <input type="checkbox"/> COUPLES | <input type="checkbox"/> ADOLESCENTS | <input type="checkbox"/> FAMILIES |

MENTAL DISORDERS/ISSUES YOU SPECIALIZE *(please check all that apply):*

- | | | |
|---|---|--|
| <input type="checkbox"/> ADD/ADHD IN CHILDREN/ADOL. | <input type="checkbox"/> EATING DISORDERS | <input type="checkbox"/> SCHIZOPHRENIA |
| <input type="checkbox"/> ADD/ADHD IN ADULTS | <input type="checkbox"/> FAITH/SPIRITUAL ISSUES | <input type="checkbox"/> SELF-ESTEEM/AWARENESS |
| <input type="checkbox"/> ANGER MANAGEMENT | <input type="checkbox"/> GAY/LESBIAN ISSUES | <input type="checkbox"/> STRESS MANAGEMENT |
| <input type="checkbox"/> ANXIETY DISORDERS | <input type="checkbox"/> FAMILY COUNSELING | <input type="checkbox"/> SUBSTANCE ABUSE |
| <input type="checkbox"/> BIPOLAR DISORDER | <input type="checkbox"/> GERIATRIC ISSUES | <input type="checkbox"/> WOMEN'S ISSUES |
| <input type="checkbox"/> BORDERLINE PERSONALITY | <input type="checkbox"/> GRIEF THERAPY | <input type="checkbox"/> MEN'S ISSUES |
| <input type="checkbox"/> CHILDHOOD DISORDERS | <input type="checkbox"/> OCD | <input type="checkbox"/> COUPLES/RELATIONSHIPS |
| <input type="checkbox"/> PARENT TRAINING | <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> PERSONALITY DISORDERS |
| <input type="checkbox"/> DISSOCIATIVE DISORDER | <input type="checkbox"/> PTSD | <input type="checkbox"/> OTHER: _____ |

PAYMENT OPTIONS *(please check all that apply):*

- | | | |
|------------------------------------|--|--|
| <input type="checkbox"/> INSURANCE | <input type="checkbox"/> MEDICAID | <input type="checkbox"/> SLIDING SCALE |
| <input type="checkbox"/> MEDICARE | <input type="checkbox"/> EXTENDED PAYMENT PLAN | <input type="checkbox"/> PRO BONO |

ARE YOU PROFICIENT IN A SECOND LANGUAGE? YES (PLEASE SPECIFY): _____ NO

ARE YOU WILLING TO SPEAK TO GROUPS? YES NO

IF SO, PLEASE LIST THE TOPICS. _____

ADDITIONAL INFORMATION *(please use reverse side if necessary):* _____

Please send completed form and a \$25 check made out to MHA-NC, Cape Fear Chapter to:

**Mental Health Association in NC, Cape Fear Chapter
P.O. Box 15141, Wilmington, NC 28408
Or call (910) 794-1722 for more information**

THANK YOU!

Received _____

Revised: January 2005