

Name and Credentials: _____

Program/Practice Name: _____

Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____

Office Ph. Number: _____ **Cell Ph. Number:** _____

Website: _____ **Email:** _____

Licensed as: (if in private practice, include license # and state): _____

Intake/Contact Person: _____

Levels of Care: (Check all that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> Detox | <input type="checkbox"/> In Patient | <input type="checkbox"/> IOP |
| <input type="checkbox"/> Partial Hospitalization | <input type="checkbox"/> Day Program | <input type="checkbox"/> Halfway House |
| <input type="checkbox"/> Residential | <input type="checkbox"/> Sober Living | <input type="checkbox"/> 3/4 Way House |
| <input type="checkbox"/> Medical Stabilization | <input type="checkbox"/> Extended Care | <input type="checkbox"/> Private Practice |
| <input type="checkbox"/> Individual | <input type="checkbox"/> Group | <input type="checkbox"/> Long Term |
| <input type="checkbox"/> Therapeutic Boarding School | | |

Other: _____

Areas of Specialization: (Check all that apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> Trauma | <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> Sexual Addiction |
| <input type="checkbox"/> Family of Origin | <input type="checkbox"/> Family Therapy | <input type="checkbox"/> Couples Therapy |
| <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Self Harm | <input type="checkbox"/> Dissociation |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety | <input type="checkbox"/> OCD |
| <input type="checkbox"/> Domestic Violence | <input type="checkbox"/> Sexual Trauma | <input type="checkbox"/> Personality Disorders |
| <input type="checkbox"/> Suicidal Ideation | <input type="checkbox"/> Medication Management | <input type="checkbox"/> PTSD |
| <input type="checkbox"/> Veterans | <input type="checkbox"/> Sexual Identity | <input type="checkbox"/> Body Dysmorphia |
| <input type="checkbox"/> Nutrition | <input type="checkbox"/> Body Image | <input type="checkbox"/> Chronic Pain |
| <input type="checkbox"/> Chronic Mental Illness | <input type="checkbox"/> Relapse Prevention | <input type="checkbox"/> Grief and Loss |
| <input type="checkbox"/> Women's issues | <input type="checkbox"/> Life Transitions | <input type="checkbox"/> Psychotic Disorders |
| <input type="checkbox"/> Learning Disabilities | <input type="checkbox"/> Developmental Disabilities | <input type="checkbox"/> Autism |
| <input type="checkbox"/> Aspergers | <input type="checkbox"/> Sociopathy | <input type="checkbox"/> Interventions |

Other: _____

Treatment Modalities: (Check all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> Cognitive Behavioral | <input type="checkbox"/> Psychodrama | <input type="checkbox"/> Art Therapy |
| <input type="checkbox"/> Hypnosis | <input type="checkbox"/> DBT | <input type="checkbox"/> Somatic Exper. |
| <input type="checkbox"/> EMDR | <input type="checkbox"/> Breath Work | <input type="checkbox"/> Hakomi |
| <input type="checkbox"/> Music Therapy | <input type="checkbox"/> Equine Therapy | <input type="checkbox"/> Individual Therapy |
| <input type="checkbox"/> Group Therapy | <input type="checkbox"/> Play Therapy | <input type="checkbox"/> Experiential |

Time Line Body Centered Neurofeedback
 Bio Feedback Massage Acupuncture
 Yoga Tai Chi Movement Therapy
 Coaching Phone Therapy Internet Counseling
Other: _____

Client Profile:

Adult Adolescent Child
 Professionals Indigent Male
 Female Gay/Lesbian Sex Offenders
 Criminal Justice Young Adults
Other: _____

Fees: _____

Insurances Accepted: _____

Additional services, accreditations, specialties, information: _____

Thank you for your time. This information is very helpful in choosing the best providers suited for each individual client's needs. If you wish to include additional written information feel free to attach that along with the completed profile form.

Please return completed forms with credit card payment by fax or mail with payment by check to:

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