



THE AMERICAN MENTAL HEALTH ALLIANCE - USA  
P.O. BOX 4075  
PORTLAND, OR 97208-4075  
TELEPHONE: (503) 222-0332  
TOLL FREE INFORMATION: 1-888-706-9933  
**www.AmericanMentalHealth.com**

**Professional Information Questionnaire – Renewing Member**

*Please complete and return to AMHA-USA immediately. Please use black ink and write or type clearly.*

Name: \_\_\_\_\_

Mailing address: \_\_\_\_\_  
\_\_\_\_\_

Practice address #1: \_\_\_\_\_

\_\_\_\_\_ Practice Phone #1 \_\_\_\_\_

Practice address #2: \_\_\_\_\_

\_\_\_\_\_ Practice Phone #2 \_\_\_\_\_

Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

**I would like to participate in an AMHA-USA list-serve (E-Mail conversation group) \_\_\_ Yes \_\_\_ No**

The purpose of this list-serve is to develop an on line-community supportive to your independent professional practice, to share practice development information, to facilitate the intellectual and professional development of AMHA-USA members and to facilitate cross-referrals.

Home phone numbers will not be published. **Home phone:** (     )

This form is required to update information in your file.

*You can help keep AMHA- USA costs for time, paper and postage low by completing this now, so reminder notices aren't necessary.*

I certify that:

- ▶ I am providing accurate information about my professional experience and skills in my **www.AmericanMentalHealth.com** web listing and notices,
- ▶ there has been no impairment of my capacity to practice my profession,
- ▶ no legal or disciplinary actions have been taken against my license.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Please answer questions on second page

**It is clear that many AMHA-USA members are not taking full advantage of their web pages. We want to improve the utility and effectiveness of this shared marketing resource for all AMHA-USA members.**

Your answers to the following questions will help AMHA-USA support the visibility of your practice on [www.AmericanMentalHealth.com](http://www.AmericanMentalHealth.com) and increase the effectiveness of your practice promotion on the website:

	YES	NO
I am comfortable working with and changing the information on my web listing.	___	___
I am willing to read the material about using and improving my enhanced web page at <a href="http://membership.americanmentalhealth.com/enhancedpages-lessons.page">http://membership.americanmentalhealth.com/enhancedpages-lessons.page</a>	___	___
I am interested to have specific questions answered about how to make best use of my web page. <i>This service is free to AMHA-USA members</i>		
I understand how to list my groups, workshops, supervision and coaching availability on my state site at <a href="http://www.AmericanMentalHealth.com">www.AmericanMentalHealth.com</a>	___	___
I want to have my own domain name	___	___
I have purchased a domain name and would like to point that name at my web page on <a href="http://www.AmericanMentalHealth.com">www.AmericanMentalHealth.com</a>	___	___
I need help to manage my web page listing; but I can find it myself	___	___
I am willing to pay a person contracted by AMHA-USA for clerical and editorial assistance to create my web page and train me to make future changes.		
<i>The rate for web clerical services will be \$25 per hour, with a minimum fee of \$50 to each member who requests clerical support.</i>	___	___
I am interested in having a personal professional web site. A site that I or my clerical staff can manage. My site would have its own domain name, my site would be linked to my web page at <a href="http://www.AmericanMentalHealth.com">www.AmericanMentalHealth.com</a>		
<i>(The cost of an AMHA-USA self-managed <b>site</b> is \$480 per year, including ISP fees. AMHA sites are self managed and can be customized for a low initial set up fee ... about \$200)</i>	___	___

**Questions? Comments?**

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**If you need clerical help to complete your web page ... please complete the following information**

**Your Clinical Practice**

- 1. Populations Served: *X all that apply***  Child 0-4  Child 5-11  Adolescent 12-19  Adults  Geriatric  Gay  Lesbian  Hearing Impaired  Spanish Speaking  other language(s) specify: \_\_\_\_\_
- 2. Modalities: *X all areas of training and experience that apply***  Individual  Couple  Family  Group  **Psychopharmacology**  Consultation to Business  Consultation to Agencies  Family Mediation  Play Therapy  Sand Tray  TA  EMDR  REM  Psychoanalysis  Hypnosis  Hypnotherapeutic regression  TFT  Music Therapy  Personality Assessment  Psychological Testing  Neuropsychological Assessment  Divorce mediation  Biofeedback  Movement therapy  Art Therapy  Imagery  Body-work  Crisis Services  Short-term  Long Term Supportive  Intensive Chemical Dependency Services  pre-tx/ post-tx Chemical Dependency Services  Home or hospital visits  Inpatient Psychiatric Services  Outdoor Therapy  Sports/ Motivation Therapy  School Based Services  Hakomi  Psychodrama  Other \_\_\_\_\_ Groups you offer: \_\_\_\_\_

- 3. Clinical / Treatment Orientations: *X all that apply***  Psychodynamic  Psychoanalytic  Psychodynamic-Interpersonal  Jungian  Cognitive  Behavioral  Gestalt  Existential  Humanistic  Constructivist/ Schema-focused  Narrative  Christian  Family of Origin  Systems  Ecological  Strengths/Wellness Orientation  Ericksonian  Object Relations  Developmental  Other specify \_\_\_\_\_

- 4. Areas of Clinical Experience & Focus:  all categories of intervention with which you have experience and training**  
***And, please, Underline to indicate categories that you prefer to treat and/or have the most experience treating.***

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Adjustment Disorders                  | <input type="checkbox"/> Developmental Disability               | <input type="checkbox"/> Panic disorders                         |
| <input type="checkbox"/> Acting-out Adolescents                | <input type="checkbox"/> Divorce adjustment                     | <input type="checkbox"/> Parenting issues                        |
| <input type="checkbox"/> Adoption issues                       | <input type="checkbox"/> Divorcing parents' concerns            | <input type="checkbox"/> Partners of sex abuse victims           |
| <input type="checkbox"/> AIDS/HIV counseling                   | <input type="checkbox"/> <b>Dissociative Identity Disorders</b> | <input type="checkbox"/> Personality Disorders                   |
| <input type="checkbox"/> Affective/mood disorders              | <input type="checkbox"/> Domestic Violence                      | <input type="checkbox"/> Phobias                                 |
| <input type="checkbox"/> Aging                                 | <input type="checkbox"/> Dream work/Dream Analysis              | <input type="checkbox"/> <b>Post Traumatic Stress Disorder</b>   |
| <input type="checkbox"/> Alcohol/Drug dependence/recovery      | <input type="checkbox"/> Drug-related issues                    | <input type="checkbox"/> <b>Post-psychiatric</b> hospitalization |
| <input type="checkbox"/> Alcohol-related family/ couple issues | <input type="checkbox"/> Dual diagnosis                         | <input type="checkbox"/> Pregnancy/post-partum                   |
| <input type="checkbox"/> Anger management                      | <input type="checkbox"/> EAP services                           | <input type="checkbox"/> Pre-marital counseling                  |
| <input type="checkbox"/> Antisocial personality disorder       | <input type="checkbox"/> Eating disorders                       | <input type="checkbox"/> Psycho-sexual disorders                 |
| <input type="checkbox"/> Anxiety Disorders                     | <input type="checkbox"/> Fertility issues                       | <input type="checkbox"/> Sexual abuse perpetrators               |
| <input type="checkbox"/> Attention Deficit Disorder            | <input type="checkbox"/> Gambling problems                      | <input type="checkbox"/> Sexual abuse victims/ child             |
| <input type="checkbox"/> Autism                                | <input type="checkbox"/> Gay couples                            | <input type="checkbox"/> Sexual abuse victims/adult              |
| <input type="checkbox"/> Bereavement/Grief                     | <input type="checkbox"/> Gender dysphoria / Gender Identity     | <input type="checkbox"/> Sexual compulsion                       |
| <input type="checkbox"/> Breast Cancer Counseling              | <input type="checkbox"/> Habit change                           | <input type="checkbox"/> Sexual dysfunctions                     |
| <input type="checkbox"/> Cancer Counseling                     | <input type="checkbox"/> Incest                                 | <input type="checkbox"/> Sight disorders/blindness               |
| <input type="checkbox"/> Children's Adjustment to Divorce      | <input type="checkbox"/> Infertility issues                     | <input type="checkbox"/> Somatoform disorders                    |
| <input type="checkbox"/> <b>Chronic Mental Illness</b>         | <input type="checkbox"/> Inter-cultural couples                 | <input type="checkbox"/> Spiritual issues                        |
| <input type="checkbox"/> <b>CMI</b> relapse prevention         | <input type="checkbox"/> Inter-racial couples                   | <input type="checkbox"/> Step-parenting issues                   |
| <input type="checkbox"/> Chronic Medical Problems              | <input type="checkbox"/> Learning problems                      | <input type="checkbox"/> Stress reduction/Stress management      |
| <input type="checkbox"/> Chronic Pain                          | <input type="checkbox"/> Lesbian couples                        | <input type="checkbox"/> Vocational/ career concerns             |
| <input type="checkbox"/> Communication Problems                | <input type="checkbox"/> Management consulting                  | <input type="checkbox"/> Weight management                       |
| <input type="checkbox"/> Conduct Disorders                     | <input type="checkbox"/> Marriage counseling                    | <input type="checkbox"/> Work related conflicts                  |
| <input type="checkbox"/> Creativity Issues                     | <input type="checkbox"/> Medically ill clients                  | <input type="checkbox"/> Other Specify: _____                    |
| <input type="checkbox"/> Cross Cultural issues                 | <input type="checkbox"/> Menopause issues                       |  |
| <input type="checkbox"/> Death and Dying                       | <input type="checkbox"/> Neurological disorders                 |  |
| <input type="checkbox"/> Depression                            | <input type="checkbox"/> Obsessive Compulsive Disorder          |  |
|  | <input type="checkbox"/> Organizational issues                  |  |

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Put your name here, to help the data-entry process

**5. Do you practice (or have experience) in hospital settings providing any of the following:**

Emergency psychiatric services  Crisis Intervention  Social services  Admissions  Intake assessment  
 Psychological Evaluations  Treatment planning;  Consultation  Treatment services  Discharge Planning

**Supervision/consultation:  whichever apply:**

Are you currently being supervised in any part of your practice?  Yes  No

Are you currently receiving consultation in any part of your practice?  Yes  No

Have you ever or are you now functioning as supervisor/consultant for any other mental health professionals?  Yes  No

If yes, please tell us how many years you have been a supervisor or consultant of other clinicians. \_\_\_\_\_years.

Are you currently engaged in any peer consultation group(s)?  Yes  No

Would you be willing to serve as a consultant to AMHA-USA professionals?  Yes  No

**12. Hospital and/or Teaching Affiliations: (if applicable)**

Institution: \_\_\_\_\_ Affiliation: \_\_\_\_\_

Institution: \_\_\_\_\_ Affiliation: \_\_\_\_\_

Institution: \_\_\_\_\_ Affiliation: \_\_\_\_\_

**To what professional and/or clinical organizations do you belong?**

Name: \_\_\_\_\_ Affiliation: \_\_\_\_\_

Name: \_\_\_\_\_ Affiliation: \_\_\_\_\_

Name: \_\_\_\_\_ Affiliation: \_\_\_\_\_

Name: \_\_\_\_\_ Affiliation: \_\_\_\_\_

Name: \_\_\_\_\_ Affiliation: \_\_\_\_\_

Other information about you and your practice important to let the public know:

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