



## Therapist Questionnaire

### Service Location

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

Physical Address: \_\_\_\_\_

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

Admin#: \_\_\_\_\_ Fax#: \_\_\_\_\_

Major Intersection: \_\_\_\_\_

Office Hours: \_\_\_\_\_ Phone Availability: \_\_\_\_\_

Website: \_\_\_\_\_ Email: \_\_\_\_\_

### Accessibility

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1a. Is the facility wheelchair accessible? Yes    No  
If not, what areas are accessible?

b. How are services made accessible for people with disabilities?

2. Do you have a TTY? Yes    No

3. Do you have access to language interpreters? Yes    No  
If yes, how is this processed and who is billed?

4. What languages do you speak?

5. What types of after hour's service do you provide clients?

6a. What are your fees?

Individual \$ \_\_\_\_\_ couples\$ \_\_\_\_\_ family\$ \_\_\_\_\_

b. Do you have sliding scale? Yes No  
If yes, please describe:

## Professional Information

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1a. Please list your educational and/or related experiences.

b. Clinical experience:

2. Do you participate in ongoing supervision? Yes No  
If yes, how often and what is the nature of your supervision?

3. Please describe your philosophy of therapy.

4. How would you describe yourself to a client?

5. Are you comfortable with your above answers #3 & #4 being passed on to callers being referred to you? Yes No

## Specialties

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1. Do you work with men? Yes No  
If yes, please outline areas?

2a. Please indicate which of the following therapy modalities you use in your counselling practice?

|  |   |
|--|---|
| <input type="checkbox"/> Art Therapy     | <input type="checkbox"/> Feminist           |
| <input type="checkbox"/> Behavioral      | <input type="checkbox"/> Jungian            |
| <input type="checkbox"/> Body Work       | <input type="checkbox"/> Psycho-educational |
| <input type="checkbox"/> Client Centered | <input type="checkbox"/> Psycho-drama       |
| <input type="checkbox"/> Cognitive       | <input type="checkbox"/> Rogerian           |
| <input type="checkbox"/> Dream Work      | <input type="checkbox"/> Other:             |

|                                      |                                 |
|--------------------------------------|---------------------------------|
| <input type="checkbox"/> Erickson    | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Existential | <input type="checkbox"/> Other: |

b) Please indicate your primary mode of therapy (Often our callers request a therapist using a primary mode or eclectic modes in their practice).

3. Please indicate which issues or client groups you have specialized training and or extensive experience working with in your practice.

|   |   |
|---|---|
| <input type="checkbox"/> Adoption<br><input type="checkbox"/> Anxiety/Panic Attacks<br><input type="checkbox"/> Addiction Issues<br>(e.g. drugs, alcohol, gambling, sex)<br><input type="checkbox"/> Bi-Polar/Manic Depression<br><input type="checkbox"/> Body Image Issues<br><input type="checkbox"/> Class issues<br><input type="checkbox"/> Childhood Abuse<br>(e.g. emotional, physical, sexual, verbal)<br><input type="checkbox"/> Depression<br><input type="checkbox"/> Disassociation<br><input type="checkbox"/> Elder Abuse<br><input type="checkbox"/> Eating Issues<br>(e.g. Anorexia, Bulimia)<br><input type="checkbox"/> Gender Issues<br><input type="checkbox"/> Immigrant/Refugee issues<br><input type="checkbox"/> Poverty issues<br><input type="checkbox"/> Partner Abuse | <input type="checkbox"/> Prescription Drugs Abuse<br><input type="checkbox"/> Relationship issues<br>(e.g. divorce separation, marriage)<br><input type="checkbox"/> Ritual abuse<br><input type="checkbox"/> Same Sex Partner Abuse<br><input type="checkbox"/> Self Injury<br><input type="checkbox"/> Sexuality Issues<br><input type="checkbox"/> Sexual Assault<br><input type="checkbox"/> Sexual Harassment<br><input type="checkbox"/> Sexual Harassment in the workplace<br><input type="checkbox"/> Suicide<br><input type="checkbox"/> Victims of torture<br><input type="checkbox"/> Long term illness: _____<br><input type="checkbox"/> Other (please specify)<br>_____<br><input type="checkbox"/> Other (please specify)<br>_____ |
|---|---|

4. Please list any other client groups or issues you provide service to:

5. Please list the most recent workshops/seminars you have attended related to women's issues and to issues of violence against women.

|       |       |
|-------|-------|
| Name  | Date: |
| Name: | Date: |
| Name: | Date: |

## Boundaries

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1. What level of support do you provide your clients beyond the actual counselling sessions? (E.g. telephone privileges-how often, how long?)
  
2. How and when are your boundaries established between you and your client? Is their flexibility? Please describe.
  
3. How do you respond to abusive behavior in a client?
  
- 4a. How do you deal with the issues of anger in therapy; specifically your clients' anger towards you in therapy?
  
- b. How do you deal with the issues of anger in therapy; specifically your anger in therapy towards a client?
  
5. When you encountered transference or counter-transference issues with your clients how do you deal with this issue(s)?

## Diversity

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- |  |     |    |
|--|-----|----|
| 1. Have you received any diversity/ anti- racism training?<br>If yes, please list. | Yes | No |
|--|-----|----|

If no, please explain.

2. How do you approach working with women from diverse backgrounds and divergent life experiences?

3. Please outline some of the challenges you encounter when working with women from a different community and experience than yourself?

## **Abused Women**

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1. How long have you been working with abused women?

2. What do you see as being the most difficult issues facing abused women?

3. Do you ever counsel women to return to their abusive partners?      Yes      No  
Please explain.

4. How would you approach finding out during the process of couple counselling that there is current abuse in the relationship?

## **Counselling Issues**

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1. How do you assist a client in dealing with flashbacks or body memories?

2. Please describe your understanding of self-injury?
3. Please describe your understanding of suicidal behavior?

## Mental Health Issues

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1. Do you identify women's mental health issues as different from men's? Yes No  
Please explain?

2. Have you/ do you recommend medication for women? Yes No  
If yes, please outline circumstances.

3. Do you offer support to women who want to stop taking medication? Yes No  
(E.g. anti-depressants)? If so, please describe what kinds of support.

## Accountability/Ethics

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1. Do you describe to any particular code of professional ethics? Yes No  
Please describe.

If yes, how does this information get passed on to your clients?

2. What professional association(s) do you belong to?

3. Is there a complaint process available to your clients? Yes No

Please describe this process.

4. Are there any outstanding complaints against you currently? Yes No  
If yes, please describe:

5. If we were to receive a complaint about your services, how would you feel most comfortable hearing about it?

By Mail

Over the Telephone

## Referrals

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1. Do you make referrals to other appropriate counsellors/therapists when you are unable to take a client? Yes No

2. Please provide names of any other counsellors you would recommend for our referral list.

|       |               |
|-------|---------------|
| Name: | Phone Number: |
| Name: | Phone Number: |

## Assaulted Women's Helpline Collateral

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Are you interested in receiving any brochures, posters or business cards about our Helpline? Yes No

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**Please fax to: (416) 364-0563**  
**For more information call (416) 364-4144 Ext 223**

Thank you from the Assaulted Women's Helpline.