MDS: LICENSED PROFESSIONAL COUNSELORS

Demographics

1. Birth date **Month** ☐☐ **Day** ☐☐ **Year** ☐☐☐☐

2. Sex: O Male O Female

3. Ethnicity
Are you Hispanic or Latino? O Yes O No

4. Race (mark one or more boxes)
- O American Indian or Alaska Native
- O Asian
- O Black or African American
- O Native Hawaiian or Other Pacific Islander
- O White

Education &Training

5. What is your highest counseling degree?
- O Bachelor's degree in counseling or related field
- O Doctoral degree in counseling or related field
- O Master's degree in counseling or related field
- O Postgraduate clinical training program

6. What year did you complete your initial counseling degree? ☐☐☐☐

7. Where did you complete your initial counseling education?

State (postal abbreviation) ☐☐

School/Program Name_____

8. Is this a CACREP accredited school?
O Yes O No

9. Please mark all counseling certifications you currently hold.

- O National Certified Counselor (NCC)
- O Approved Clinical Supervisor (ACS)
- O Other _____

10. Do you currently hold a counseling license?

O Yes O No

11. What year did you obtain your initial counseling license? ☐☐☐☐

12. Where did you obtain your initial counseling license?

State (postal abbreviation) ☐☐

13. Do you currently hold a counseling license in any state?

O Yes O No

13A. If yes, which state(s)?

State (postal abbreviation) ☐☐ State (postal abbreviation) ☐☐

13B. If yes, what is your license number for each state?

_____ _____

14. Please mark any additional licenses you currently hold.

O Licensed Social Worker
O Licensed Marriage and Family Therapist
O Licensed Psychologist
O Licensed Substance Abuse/Addiction Counselor
O Licensed Creative Arts Therapist
O Licensed Psychoanalyst
O Other_____

Practice Characteristics

15. What is your employment status? (mark all that apply)

O Actively working in a mental health counseling position that requires a mental health counseling license
O Actively working in a mental health counseling position that does not require a mental health counseling license
O Actively working in a field other than mental health counseling
O Not currently working
O Retired

16. For all positions held, indicate the average number of hours spent per week (excluding on-call hours) on each mental health counseling major activity:

Direct Client care	Clinical Supervision/ Instruction	Clinical/Community Consultation and Prevention	Administration	Other	**Total hours**
☐☐	☐☐	☐☐	☐☐	☐☐	☐☐

OPTIONAL16A. For all direct client care mental health activities, indicate the average number of hours spent per week (excluding on-call hours) on each major activity:

Assessment / Evaluation ☐☐
Treatment planning and team consultation ☐☐
Treatment: ☐☐

17. How many weeks did you work as a licensed professional counselor in the past year: ☐☐

18. How many weeks do you plan to work as a licensed professional counselor in the next year:

☐☐

19. Do you have a National Provider Identification (NPI) number?

O No O Yes: ☐☐☐☐☐☐☐☐☐☐

****The remaining items should be completed only by licensed professional counselors practicing direct client care.****

20. Direct Client Care: Practice Locations

What is the location of sites where you spend the most time providing direct client care:

Principal practice site	**Secondary Practice Site (if applicable)**
Zip Code of practice site: ☐☐☐☐☐	Zip Code of practice site: ☐☐☐☐☐
Direct care hours per week at site*: ☐☐	Direct care hours per week at site*: ☐☐

ALTERNATE

20. Direct Client Care: Practice Locations

What is the location of sites where you spend the most time providing direct client care:

Principal Location Address

_____
Number Street

_____
City/Town State

Zip Code ☐☐☐☐☐

Secondary Location Address (if applicable)

_____
Number Street

_____
City/Town State

Zip Code ☐☐☐☐☐

21. Which best describes the type of setting that most closely corresponds to your principal and secondary (if applicable) direct client care practice location(s): (Select One)

	Principal	Secondary
Ambulatory Care Facility		
Community health center	O	O
Mental health clinic	O	O
Methadone clinic	O	O
Primary or specialist medical care	O	O
Specialized substance abuse treatment facility	O	O
Child welfare	O	O
Criminal justice	O	O
Hospital		
Federal Government hospital	O	O
Non-federal hospital: General Medical	O	O
Non-federal hospital: Psychiatric	O	O
Non-federal hospital: Other - e.g. nursing home unit	O	O
Private practice	O	O
Rehabilitation	O	O
Residential setting	O	O
School health service	O	O
In-Home setting	O	O
Other setting (specify):_____	O	O

22. What are your employment plans for the next 12 months?

O Increase hours
O Decrease hours
O Seek non-clinical job
O Retire
O Continue as you are
O Unknown

OPTIONAL

23. Is your principal practice site formally affiliated with a network of other practices or health providers?

O No
O Yes, Staff Model HMO
O Yes, Medical-Hospital Organization
O Yes, Independent Practice Association
O Yes, Federally Qualified Health Center
O Yes, Team-Based Care
O Yes, other: _____

24. Which of the following best describes your current employment arrangement at your principal practice location?

O Self employed
O Salaried employment
O Hourly employment
O Locum tenens / temporary
O Other (specify): _____

25. Number of licensed professional counselors at each practice location:

Principal ☐☐☐ Secondary ☐☐☐

26. Are you able to communicate with clients in a language other than English?

O Yes O No

If yes – What language(s)? _____