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?**
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.

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

Practice Characteristics

15. What is your employment status? (mark all that apply)
☐ Actively working in a mental health counseling position that requires a mental health counseling license
☐ Actively working in a mental health counseling position that does not require a mental health counseling license
☐ Actively working in a field other than mental health counseling
☐ Not currently working
☐ 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:

<table>
<thead>
<tr>
<th>Direct Client care</th>
<th>Clinical Supervision/ Instruction</th>
<th>Clinical/Community Consultation and Prevention</th>
<th>Administration</th>
<th>Other</th>
<th>Total hours</th>
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OPTIONAL 16A. 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
   Zip Code of practice site:
   Direct care hours per week at site:

   Secondary Practice Site (if applicable)
   Zip Code of practice 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)
Ambulatory Care Facility

Principal Secondary
- Community health center 0 0
- Mental health clinic 0 0
- Methadone clinic 0 0
- Primary or specialist medical care 0 0
- Specialized substance abuse treatment facility 0 0
- Child welfare 0 0
- Criminal justice 0 0

Hospital

Principal Secondary
- Federal Government hospital 0 0
- Non-federal hospital: General Medical 0 0
- Non-federal hospital: Psychiatric 0 0
- Non-federal hospital: Other - e.g. nursing home unit 0 0
- Private practice 0 0
- Rehabilitation 0 0
- Residential setting 0 0
- School health service 0 0
- In-Home setting 0 0
- Other setting (specify): ____________________________ 0 0

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)? ______________________