

**Texas Council of Chiropractic Orthopedist  
CREDENTIAL QUESTIONNAIRE**

**To: Applicants**

**Purpose: Membership eligibility**

**All questions must be answered**

**Former member**

**New Applicant**

1. Name \_\_\_\_\_ Date of birth \_\_\_\_\_  
Office Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone(\_\_\_\_) \_\_\_\_\_  
Mailing address (if different from above) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
2. a. Chiropractic college where you graduated? \_\_\_\_\_  
b. What year? \_\_\_\_\_
3. a. When did you graduate from a post-graduate chiropractic orthopedic course?  
\_\_\_\_\_  
b. From what college? \_\_\_\_\_  
How many hours of study? \_\_\_\_\_  
c. Do you hold a certificate from the college showing the successful completion of the course? \_\_\_\_\_
4. a. Other Post Graduation Certifications? \_\_\_\_\_  
Where received? \_\_\_\_\_  
How many years of pre-chiropractic college? \_\_\_\_\_  
b. Do you hold any specialty certificates? \_\_\_\_\_  
By whom conferred? \_\_\_\_\_  
Please state specialty \_\_\_\_\_
5. a. How many years have you been in practice? \_\_\_\_\_  
b. Full time \_\_\_\_\_ Part time \_\_\_\_\_  
c. How long at the above address? \_\_\_\_\_  
d. List previous locations where you have practiced on the reverse side of this page \_\_\_\_\_  
e. In what states are you licensed? \_\_\_\_\_  
f. Numbers and dates of your state licenses \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. List all professional organizations of which you are a member
1. \_\_\_\_\_ 2. \_\_\_\_\_  
 3. \_\_\_\_\_ 4. \_\_\_\_\_
7. a. Do you practice alone, or in group practice? \_\_\_\_\_  
 b. If group, what is the specialty, if any, of the other doctors? \_\_\_\_\_  
 \_\_\_\_\_  
 c. Do you have a chiropractic assistant? \_\_\_\_\_  
 Full time \_\_\_\_\_ Part time \_\_\_\_\_  
 d. Any malpractice claims against you/pending? \_\_\_\_\_  
 Any felony charges/convictions? \_\_\_\_\_
- 8 Do you advertise? Yes \_\_\_\_\_ No \_\_\_\_\_
- |                       |                      |
|-----------------------|----------------------|
| a. Yellow pages _____ | b. Newspapers _____  |
| 1. Listing only _____ | c. Direct mail _____ |
| 2. Column box _____   | d. Radio or TV _____ |
| 3. Display _____      | e. Web page _____    |
| 4. Size _____         | f. Other _____       |
- 9 Have you at any time lectured, taught, conducted or organized educational scientific, or economic seminars or symposia? \_\_\_\_\_
- a. What subjects? \_\_\_\_\_  
 b. Dates and places \_\_\_\_\_  
 c. For what groups or organization? \_\_\_\_\_
- 10 What percentage of your practice consists of orthopedics? \_\_\_\_\_  
 \_\_\_\_\_
- 11 Do you indicate that you specialize in chiropractic orthopedics? \_\_\_\_\_
- a. On your letterhead and professional cards? \_\_\_\_\_  
 b. In the yellowpages? \_\_\_\_\_
- 12 Do you do any plaster cast immobilization of:
- a. Extrimities \_\_\_\_\_  
 b. Spine \_\_\_\_\_
- 13 Do you custom fit supports, braces and other orthopedic appliances where indicated? \_\_\_\_\_
- 14 Do you have professional contracts with any orthopedic surgeons or other medical or paramedical specialist? \_\_\_\_\_
- 15 Do you have a good two-way inter professional relationship with these specialists in connection with referrals? \_\_\_\_\_

16 a. Do you take a complete case history and give an appropriate orthopedic examination to every new patient? \_\_\_\_\_

b. Do you keep daily visit records as to:

1. Subjective symptoms \_\_\_\_\_ 2. Objective signs \_\_\_\_\_

3. Treatment \_\_\_\_\_

17 a. Do you have facilities available for biochemical laboratory examination? \_\_\_\_\_

b. Do you utilize these facilities? \_\_\_\_\_

18 Types of radiographs taken:

a. Diagnostic, of area of involvement \_\_\_\_\_

b. Full spine \_\_\_\_\_

19 Which of the following modalities do you use?

Ultrasound ( ) Diathermy ( )

Galvanism ( ) Sine wave ( )

Infrared ( ) Ultraviolet ( )

Cryotherapy ( ) Hydrotherapy ( )

Fomentation packs ( ) Intermittent Traction ( )

TNS ( )

20 Do you perform FCE \_\_\_\_\_. Do you do Active Therapy or Rehab \_\_\_\_\_  
Work Conditioning or Work Hardening \_\_\_\_\_.

21. List all therapeutic and/or diagnostic instruments you use, not listed above \_\_\_\_\_

22. Will you permit a credentials committee member to check and evaluate your office personally in due time? \_\_\_\_\_

**I HEREBY CERTIFY THAT THE INFORMATION CONTAINED HEREIN IS TRUE TO THE BEST OF MY KNOWLEDGE.**

Date: \_\_\_\_\_

Signature \_\_\_\_\_