# CHIROPRACTIC QUESTIONNAIRE FOR PROFESSIONAL LIABILITY COVERAGE

**Please return the questionnaire within 14 days** **Policy Number:** _____

First name: _____ Middle name: _____ Last name: _____

☐ Male ☐ Female License # and State: _____

Professional email address: _____Office phone: _____

## Section I – General Information

1. Do you perform any procedures outside of your clinical or specialty training? ☐ Yes ☐ No
2. Are you currently board certified? ☐ Yes ☐ No
   Board Name: _____ Year: _____
3. Have you ever failed to pass a board exam? ☐ Yes ☐ No
4. Are you currently a member of any chiropractic association or society? ☐ Yes ☐ No
   If yes, name: _____
5. Is laser therapy utilized in your practice? ☐ Yes ☐ No
   If yes, please list the laser procedures: _____
6. Please check any of the following procedures you perform:

   ☐ Homeopathic remedies ☐ Chiropractic surgery ☐ Manipulation under anesthesia (MUA)

   ☐ Cranial adjustments ☐ Video fluoroscopy ☐ Cosmetic chiropractic

   ☐ Prescribe narcotics or medicine ☐ X-ray patients ☐ Other: _____
7. Is a written Informed Consent obtained from the patient prior to the procedure? ☐ Yes ☐ No
   (Please include a copy of the Informed Consent form)
8. Do you utilize specific screening procedures to determine the appropriate candidates before treatment? ☐ Yes ☐ No
9. Do you sell vitamins, food supplements, herbs, homeopathic remedies out of your office? ☐ Yes ☐ No

10. Are you licensed to practice acupuncture? ☐ Yes ☐ No

11. Approximately how many patients are treated by you per week? ☐ Yes ☐ No

12. Do you provide anesthesia to patients? ☐ Yes ☐ No
    If yes, please complete Section II.

## Section II – Surgical/Anesthesia

13. Facility Name: _____ ☐ Office/Clinic ☐ Surgical Center ☐ Hospital

14. Please indicate the type(s) of anesthesia provided:

    ☐ Oral ☐ Intramuscular Sedation ☐ Intravenous Sedation ☐ General Anesthesia

    ☐ Tumescent Anesthesia ☐ Other _____

15. In case of an emergency please check all types of basic life support/resuscitative equipment available:

    ☐ Crash Cart ☐ Defibrillator ☐ ER Pharmaceutical Kit ☐ Oxygen Mask ☐ Pulse Oximeter

    ☐ Other: _____

I hereby warrant and represent that the foregoing information is true and correct. I understand and agree that this questionnaire and the statements therein become a part of the policy. I further understand and agree (1) that any policy shall be issued in reliance upon the warranties and representations made herein; (2) if this questionnaire contains any false statements, the intent to deceive will be presumed; (3) any false statement or concealment will void all coverage.

Signature: _____

Printed Name: _____ Date Signed: _____