



SELF-ASSESSMENT QUESTIONNAIRE

PURPOSE

The purpose of this document is to help you strive towards optimal clinical proficiency and provide the best care possible to your patients.

Self assessment consists of two parts – a self-reflective questionnaire and a plan of action summary sheet. In addition, there is an accompanying handbook to help you complete the questionnaire.

The self assessment questionnaire is designed to help you reflect upon your current professional proficiency, identify areas of strengths and areas for improvement, and to help you develop a learning plan that will address those areas that need improvement. There are a total of eight sections. All relevant sections must be completed, including the “Learning Objectives” section.

You will not be required to submit your self assessment questionnaire to CCO. It is for your personal review only.

The handbook contains important information that explains the clinical relevance and professional standards associated with your response. Please review the relevant parts of the handbook while you are completing the questionnaire.

PLAN OF ACTION SUMMARY SHEET

The plan of action summary sheet will assist you in developing your learning plan. Please complete the summary sheet, sign it and date it, and maintain it in your professional portfolio. Your peer assessor will review your summary sheet as part of the peer and practice assessment. You may also be randomly selected to submit your plan of action summary sheet to the Quality Assurance Committee for review.

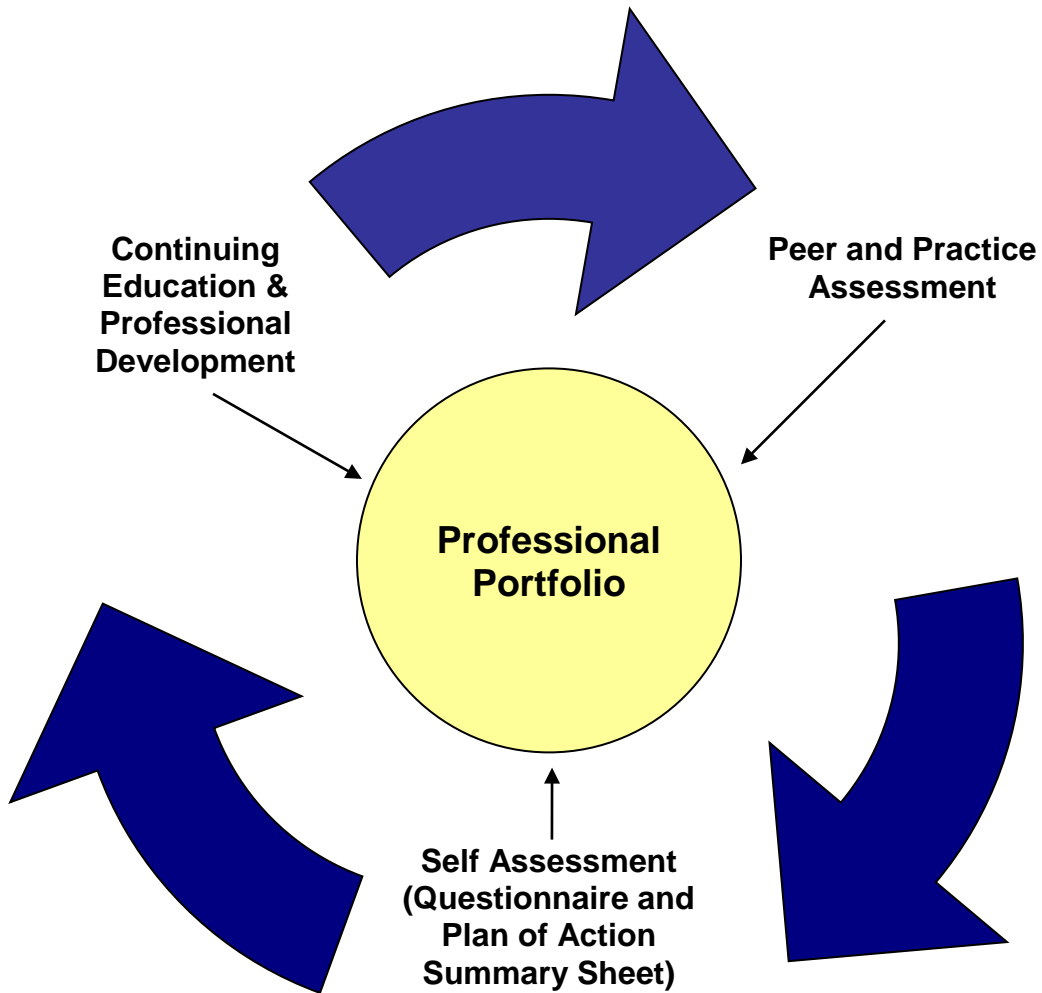
Sample plan of action summary sheets are enclosed in the handbook.

COMPLETION

You are required to complete the self-assessment questionnaire and plan of action summary sheets every two years.

INTEGRATION

The following diagram illustrates the integration of the self assessment and continuing education initiatives of the Quality Assurance Committee.



INSTRUCTIONS

Please answer each question using the scale provided. For example, the question on the intensity of the patient's pain. If you always ask this question during the patient history, mark 'always'. If you sometimes ask this question during the patient history, mark 'sometimes'.

Please note, the scale does not necessarily reflect a strength or a weakness in your practice. For example, marking a question as "never" does not necessarily mean that you have a weakness in this area. It may simply mean that this particular question does not apply to your practice area or style.

Scale: Never
Rarely
Sometimes
Usually
Always

CONFIDENTIALITY

Your self assessment questionnaire is for your professional growth and development only. This information will not be shared with anyone from CCO.

Your completed Plan of Action Summary Sheet, however, will make up part of your Professional Portfolio, which will be reviewed as part of the peer and practice assessment process.

As with all Quality Assurance programs, pursuant to the *Regulated Health Professions Act, 1991*, any information collected from the Plan of Action Summary Sheet will be confidential within the Quality Assurance Committee. No other CCO committee will have access to this information.

Please refer to the CCO's website (www.cco.on.ca) for all relevant regulations, standards of practice, policies and guidelines. Government legislation is posted on www.e-laws.gov.on.ca. In the event of any inconsistency between this document and the legislation that affects chiropractic practice, the legislation governs.

I DOCTOR-PATIENT INTERACTION

1. History Taking

Please indicate how often you ask patients the questions outlined below with respect to gathering information about their chief complaint/main concern during the interview.

For the purpose of this evaluation, please assume you already know the patient's age and gender (based on intake forms) and the patient's answers refer to his/her particular condition(s).

A. Patient's Main Concern (the Problem)

| | Never | Rarely | Sometimes | Usually | Always |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. I provide a private consultation with new patients | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>I ask and communicate to the patient about:</i> | | | | | |
| 2. The reason for his/her visit | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. His/her specific condition, problem, concern and/or goals of care | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. His/her goals for attending the office | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. The location of the pain, problem or concern | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. The onset of pain, problem or concern (when and how it started) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. The duration of the pain, problem or concern (how long the patient has had this problem) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. The relieving factors | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. The frequency of the pain, problem or concern (how often the patient experiences pain) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. The intensity (mild, moderate, severe, or on a 1 to 10 scale) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. The characteristics of pain, problem or concern (throbbing, burning, tingling, sharp, dull) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| | Never | Rarely | Sometimes | Usually | Always |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 12. The aggravating factors | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Radiations | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. The associated symptoms (e.g., bowel/bladder disorder in cases of low back pain, headache with neck pain) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Prior occurrence | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>I implement the following in my practice:</i> | | | | | |
| 16. Condition-specific questionnaires – Oswestry ¹ , NDI ² , DASH ³ , other | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Pain visual analog scale | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Global wellbeing scale or equivalent | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Custom-designed questionnaires | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Other | | | | | |
| (a) _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Learning Objectives

Based on the above section (I,1A), I will make changes to my practice.

Yes No

Based on what I learned in this section, I will:

¹ Low back disability index
² Neck Disability Index
³ Disability, Arm, Shoulder, Hand

B. General Information about the Patient (the Person)

| | Never | Rarely | Sometimes | Usually | Always |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <i>I ask the patient about ... (this includes the use of a questionnaire that will be discussed with the patient):</i> | | | | | |
| 21. Systems review (e.g., breathing, circulation, digestion) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Drug profile – prescription drugs | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Drug profile – over-the-counter medications | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Supplements – nutraceuticals (e.g., vitamins, minerals, homeopathic remedies) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Lifestyle | | | | | |
| a) marital status | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b) number of children | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c) level of stress | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d) tobacco use | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e) anything else that would adversely affect care | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Occupation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Sleep position (side, prone, supine) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Exercise | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Family history of this problem | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Relevant family history (e.g., cancer, heart disease, diabetes) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Allergies | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. Recreational activities | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 33. Dietary habits | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 34. Medical physician's name | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 35. Date of last physical/medical visit | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 36. Past illnesses | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| | Never | Rarely | Sometimes | Usually | Always |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 37. Any relevant medical/health reports and diagnostic images | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 38. Any other health concerns (secondary complaints) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 39. I provide a verbal summary to the patient, demonstrating the patient's goals for attending the office | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Learning Objectives

Based on the above section (I,1B), I will make changes to my practice.

Yes No

Based on what I learned in this section, I will:

2. Physical Assessment

| | Never | Rarely | Sometimes | Usually | Always |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 40. I obtain informed consent prior to performing any examination. ⁴ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 41. I perform a physical assessment to assess dysfunctions and disorders of the structure and function of the spine and the effect on the nervous system | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 42. I perform a physical assessment to assess dysfunctions and disorders of the joints | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

⁴ Refer to Section II (3) of this document and Standard of Practice S-013: Consent.

| | Never | Rarely | Sometimes | Usually | Always |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <i>I perform some or all of the following procedures:</i> | | | | | |
| 43. Bilateral weight scales | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 44. Blood pressure/pulse testing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 45. Leg length checks | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 46. Muscle function testing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 47. Neurological tests | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 48. Orthopedic tests | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 49. Palpation/motion palpation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 50. Posture evaluation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 51. Range of motion | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 52. Reflexes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 53. SEMG | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 54. Sensory testing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 55. Testing for non-organic signs | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 56. Thermography | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 57. Trigger points | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 58. Radiographic Examination | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 59. Other | | | | | |
| a) _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b) _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c) _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Learning Objectives

Based on the above section (1,2), I will make changes to my practice.

Yes No

Based on what I learned in this section, I will:

3. Ordering, Taking and Interpreting Radiographs

| | Yes | No | | | |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 60. I am familiar with standard of practice S-006: Ordering, Taking and Interpreting Radiographs ⁵ | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 61. I take my own radiographs | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| | Never | Rarely | Sometimes | Usually | Always |
| 62. My standard clinical workup includes the following: | | | | | |
| a) reviewing previous radiographs (if available) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b) performing a history and examination | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c) the specific reason for which the radio-diagnostic examination is being conducted (e.g., differential diagnosis, care planning indicators) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d) consideration of the benefits, limitations, contraindications, risks and safety protocols | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e) interpretation of the radiograph | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

⁵ Refer to Standard of Practice S-006: Ordering, Taking and Interpreting Radiographs

| | Never | Rarely | Sometimes | Usually | Always |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| f) appropriate and timely follow-up | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g) recommendations for care | | | | | |
| 63. I maintain radiological records, logs and reports in accordance with the standard of practice | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 64. I comply with the billing guidelines, consent, patient selection and equipment registration components (if application) of the standard of practice | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 65. I store x-ray reports in the record of personal health information | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Learning Objectives

Based on the above section (1,3), I will make changes to my practice.

Yes No

Based on what I learned in this section, I will:

4. Diagnosis or Clinical Impression

| | Never | Rarely | Sometimes | Usually | Always |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <i>Based on the patient interview and physical assessment, I am able to provide the following information to my patients:</i> | | | | | |
| 66. Diagnosis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 67. A clinical impression (in the absence of a diagnosis) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| | Never | Rarely | Sometimes | Usually | Always |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 68. Time frame (acute, chronic, recurrent) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 69. Intensity (mild, moderate, severe) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 70. Cause (postural, traumatic, lifestyle, genetic, etc.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 71. Anatomical location/structure | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 72. Pathology (subluxation/joint dysfunction, sprain, strain, etc.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 73. Associated symptoms | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Learning Objectives

Based on the above section (1,4), I will make changes to my practice.

Yes No

Based on what I learned in this section, I will:

5. Report of Findings

| | Never | Rarely | Sometimes | Usually | Always |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <i>I include the following components in my Report of Findings (Doctor's Report):</i> | | | | | |
| 74. Convey the diagnosis or clinical impression to the patient | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 75. Provide the patient with prognosis (if applicable) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 76. Discuss schedule or frequency of appointments with the patient | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 77. Discuss type of care (crisis or acute, supportive, maintenance, wellness/prevention/health promotion) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| | Never | Rarely | Sometimes | Usually | Always |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 78. Explain in plain language what therapies will be provided to the patient to successfully manage his/her chief complaint, condition or concern | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 79. Discuss fee payment options, consistent with CCO regulations and guidelines ⁶ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 80. Refer for further investigation or consultation with another health professional, if necessary | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Learning Objectives

Based on the above section (1,5), I will make changes to my practice.

Yes No

Based on what I learned in this section, I will:

6. Chiropractic Care

| | Never | Rarely | Sometimes | Usually | Always |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 81. I obtain informed consent prior to performing any care ⁷ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 82. I provide care consistent with the examination findings, diagnosis or clinical impression, report of findings and plan of care | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

⁶ Refer to Regulation R-008: Professional Misconduct (Business Practices section), and Guideline G-008: Business Practices.

⁷ Refer to Section II (3) of this document and Standard of Practice S-013: Consent.

| | Never | Rarely | Sometimes | Usually | Always |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 83. I provide care consistent with the patient's overall goals | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>I provide the following treatments/therapies/care:</i> | | | | | |
| 84. Spinal adjustments/manipulation (High Velocity, Low Amplitude, thrusting moves, hands-on, instrument, drop table, pelvic wedges/blocks, other) ⁸ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 85. Non-spinal adjustments/manipulation (HVLA thrusting moves, hands-on, instrument, drop table, pelvic wedges/blocks, other) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 86. Mobilizations/stretching (manual or electric) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 87. Soft tissue therapies (manual or instrument) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 88. Acupuncture ⁹ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 89. Orthotics ¹⁰ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 90. Assistive Devices | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 91. Additional adjunctive techniques, technologies, devices or therapeutic procedures (e.g., interferential current, ultrasound, laser) ¹¹ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 92. Exercise counselling | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 93. Nutritional counselling | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 94. Other | | | | | |
| a) _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b) _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c) _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

⁸ Refer to Standard of Practice S-001: Chiropractic Scope of Practice

⁹ Refer to Standard of Practice S-017: Acupuncture, and section II (6) of this document.

¹⁰ Refer to Standard of Practice S-012: Orthotics, and Section II (9) of this document.

¹¹ Refer to Standard of Practice S-001: Chiropractic Scope of Practice

Learning Objectives

Based on the above section (1,6), I will make changes to my practice.

Yes No

Based on what I learned in this section, I will:

7. Advice Given to Patients

| | Never | Rarely | Sometimes | Usually | Always |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 95. I provide comprehensive home care instructions to the patient (e.g., if they are to apply ice, where, how long and how often) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 96. I provide stretches and/or exercises to the patient, where appropriate | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 97. I discuss healthy lifestyle choices, where appropriate | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 98. I discuss preventive strategies with the patient, where appropriate | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 99. I make every effort to monitor and record patient compliance with the advice given to patients | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Learning Objectives

Based on the above section (1,7), I will make changes to my practice.

Yes No

Based on what I learned in this section, I will:

8. Outcome Measures / Re-assessment

| | Never | Rarely | Sometimes | Usually | Always |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <i>I use some or all of the following outcome measure(s)¹² to monitor the progress of my patients:</i> | | | | | |
| 100. Activities of daily living questionnaires | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 101. Analog pain scales | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 102. Any questionnaire designed to have the patient compare his/her current and past health and/or lifestyle ratings | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 103. Bilateral weight scales | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 104. Blood pressure/pulse testing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 105. Disability questionnaires | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 106. Exercise compliance | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 107. Leg length checks | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 108. Muscle function testing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 109. Neurological tests | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 110. Orthopedic tests | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 111. Palpation/motion palpation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

¹² Refer to Standard of Practice S-002: Record Keeping

| | Never | Rarely | Sometimes | Usually | Always |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 112. Posture evaluation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 113. Range of motion | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 114. Reflexes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 115. SEMG | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 116. Sensory testing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 117. Testing for non-organic signs | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 118. Thermography | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 119. Trigger points | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 120. Radiographic image | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 121. Other | | | | | |
| a) _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b) _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c) _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 122. I compare previous assessments to the current re-assessment to evaluate the patient's progress | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 123. I make changes to my care plan based on the outcome measures I use in my re-assessments | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 124. I revisit consent if I am proposing a new care plan or if a new condition has been presented | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 125. I perform a re-assessment when clinically necessary and, in any event, no later than each 24 th visit | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Learning Objectives

Based on the above section (1,8), I will make changes to my practice.

Yes No

Based on what I learned in this section, I will:

II PROFESSIONAL RESPONSIBILITIES

1. General Knowledge of Legislation, Regulations, Standards of Practice, Policies and Guidelines

| | Never | Rarely | Sometimes | Usually | Always |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 126. I review relevant government legislation including, but not limited to, the <i>Regulated Health Professions Act</i> , the <i>Chiropractic Act</i> , the <i>Healing Arts Radiation Act</i> , the <i>Personal Health Information Protection Act</i> and the <i>Health Care Consent Act</i> ¹³ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 127. I review CCO's regulations and standards of practice | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 128. I review CCO's policies and guidelines | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 129. I review CCO's website for updates as follows: | Yes | No | | | |
| a) weekly | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| b) monthly | <input type="checkbox"/> | <input type="checkbox"/> | | | |

¹³ Review to CCO's web site – www.cco.on.ca.

- | | Never | Rarely | Sometimes | Usually | Always |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| c) every six months | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| d) yearly | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| | Never | Rarely | Sometimes | Usually | Always |
| 130. I am able to answer patients' questions on relevant legislation, standards of practice, policies and guidelines | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Learning Objectives

Based on the above section (II,1), I will make changes to my practice.

Yes No

Based on what I learned in this section, I will:

2. Scope of Practice

- | | Never | Rarely | Sometimes | Usually | Always |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 131. I practise within the scope of practice as defined in the <i>Chiropractic Act, 1991</i> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 132. I communicate the scope of practice to patients | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 133. I communicate to my patients when I am practising a procedure that is in the public domain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 134. I have achieved, maintain and can demonstrate clinical competency in every diagnostic and therapeutic procedure that I perform | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

- | | Never | Rarely | Sometimes | Usually | Always |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 135. Every diagnostic and therapeutic procedure I use is taught in the core curriculum, post-graduate curriculum, or continuing education division of an accredited educational institution | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 136. I understand what practices are outside the scope of chiropractic practice (e.g., mobile digital iriscopes system, dark field microscopy, vega testing, hyperbaric oxygen therapy, pelvic and prostate examinations) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Learning Objectives

Based on the above section (II,2), I will make changes to my practice.

Yes No

Based on what I learned in this section, I will:

3. Consent

- | | Never | Rarely | Sometimes | Usually | Always |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 137. I obtain informed consent from each patient prior to examination and treatment | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 138. Consent that I receive from my patients is: | | | | | |
| a) fully informed | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b) voluntarily given | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| | | Never | Rarely | Sometimes | Usually | Always |
|------|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| c) | related to the patient's conditions and circumstances | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d) | not obtained through fraud or misrepresentations | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e) | evidenced in a written form signed by the patient or otherwise documented in the patient health record | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 139. | Informed consent in my practice includes a discussion of the following: | | | | | |
| a) | the recommended examination or treatment | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b) | why the patient should have the examination or treatment | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c) | alternatives to the examination or treatment | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d) | effects, material risks and side-effects of the proposed examination or treatment and alternative examinations or treatments | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e) | what might happen if the patient does not have the examination or treatment | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 140. | I obtain and update informed consent during treatment if: | | | | | |
| a) | I recommend a new examination, treatment, technique or technology | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b) | there are significant changes in the patient's condition | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| | Never | Rarely | Sometimes | Usually | Always |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| c) there are significant changes in the material risk to a patient | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 141. I understand that for a patient to have capacity to consent to examination or treatment, he/she must be able to understand the information that is relevant to making a decision about the examination or treatment and able to appreciate the reasonably foreseeable consequences to such a decision | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 142. I seek consent from the appropriate parent, guardian, or substitute decision maker to treat patients who may not have the capacity to consent to an examination or treatment | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Learning Objectives

Based on the above section (II,3), I will make changes to my practice.

Yes No

Based on what I learned in this section, I will:

4. Reporting Obligations

| | Never | Rarely | Sometimes | Usually | Always |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 143. I am familiar with and comply with my legal obligation to report alleged sexual abuse by any health care provider to the appropriate regulatory college | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 144. I am familiar with and comply with reporting obligations in accordance with Guideline G-010: Mandatory and Permissive Reporting ¹⁴ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 145. I am familiar with and comply with the legal obligation to report specified diseases to the local Medical Officer of Health (e.g., HIV, tuberculosis, measles, mumps) ¹⁵ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 146. I am familiar with and comply with the legal obligation to report child abuse, nursing home or retirement home harm, and occupational health and safety risk | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Learning Objectives

Based on the above section (II,4), I will make changes to my practice.

Yes No

Based on what I learned in this section, I will:

¹⁴ Refer to Guideline G-010: Mandatory and Permissive Reporting

¹⁵ Refer to Standard of Practice S-004: Reporting of Diseases

5. Interprofessional Obligations

| | Never | Rarely | Sometimes | Usually | Always |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 147. I foster collaborative relationships with other health care providers and stakeholders | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 148. I effectively communicate with other health care providers to ensure quality patient care | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 149. I consider and respect opinions from other chiropractors and other health care providers | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 150. I refer patients to other health care providers when in their best interests | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Learning Objectives

Based on the above section (II,5), I will make changes to my practice.

Yes No

Based on what I learned in this section, I will:

6. Acupuncture

| | Yes | No | | | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 151. I am familiar with standard of practice S-017: Acupuncture | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 152. I use acupuncture in my practice. (If no, go to section 7) | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 153. I have appropriate training in acupuncture as described in the standard of practice | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 154. I understand that I may not use the title “acupuncturist” unless I am a member of the College of Traditional Chinese Medicine Practitioners and Acupuncturists of Ontario | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| | Never | Rarely | Sometimes | Usually | Always |
| 155. I obtain informed consent prior to performing acupuncture treatments ¹⁶ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 156. I use clean needle techniques | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 157. I evaluate the contra-indications to the use of acupuncture | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 158. I react appropriately in response to accidents and untoward reactions as a result of acupuncture treatments | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 159. I take the necessary precautions to prevent injury as a result of acupuncture treatments | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

¹⁶ Refer to Section II (3) in this document.

Learning Objectives

Based on the above section (II,6), I will make changes to my practice.

Yes No

Based on what I learned in this section, I will:

7. Members of More Than One Health Profession

- | | Yes | No | | | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 160. I am familiar with standard of practice S-011: Members of More Than One Health Profession | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 161. I am a member of more than one health profession. (<i>If no, go to section 8</i>) | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| | Never | Rarely | Sometimes | Usually | Always |
| 162. I maintain, delineate and document professional services of different health professions in the patient health record, financial record, billing policies and procedures, and documentation relating to consent | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 163. I clearly communicate to patients in which role I am acting when providing treatment | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 164. I communicate to patients when I am practising outside my chiropractic scope of practice | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

165. I understand and comply with the regulatory framework of the profession in which capacity I am practising

Learning Objectives

Based on the above section (II,7), I will make changes to my practice.

Yes No

Based on what I learned in this section, I will:

8. Chiropractic Care of Animals

- | | Yes | No |
|--|--------------------------|--------------------------|
| 166. I am a familiar with standard of practice S-009: Chiropractic Care of Animals | <input type="checkbox"/> | <input type="checkbox"/> |
| 167. I provide chiropractic care to animals. <i>(If no, go to section 9)</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| 168. I have appropriate training in animal chiropractic as described in the standard of practice | <input type="checkbox"/> | <input type="checkbox"/> |
| 169. I maintain a separate portion of my office for chiropractic treatment of animals | <input type="checkbox"/> | <input type="checkbox"/> |

- | | Never | Rarely | Sometimes | Usually | Always |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 170. I defer the primary responsibility for the health care of the animal to a member of the College of Veterinarians of Ontario, who is responsible for appropriate history taking, comprehensive examination, and the overall treatment/ management of the animal | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 171. I obtain informed and voluntary consent from the owner of the animal ¹⁷ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 172. I maintain separate appointment books, health and financial records | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Learning Objectives

Based on the above section (II,8), I will make changes to my practice.

Yes No

Based on what I learned in this section, I will:

9. Orthotics

- | | Yes | No |
|---|--------------------------|--------------------------|
| 173. I am familiar with standard of practice S-012: Orthotics | <input type="checkbox"/> | <input type="checkbox"/> |
| 174. I provide orthotics to my patients. (If no, go to section 10) | <input type="checkbox"/> | <input type="checkbox"/> |

¹⁷ Refer to Section II (3) of this document.

| | Yes | No | | | |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 175. I have appropriate training, skill and competence to prescribe, manufacture, sell and/or dispense orthotics, as described in the standard of practice | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| | Never | Rarely | Sometimes | Usually | Always |
| 176. I use appropriate examination and diagnosis of patients with conditions within the scope of practice of chiropractic which may reasonably be expected to benefit from the use of orthotics | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 177. I evaluate indications and contra-indications of orthotics for individual patients | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 178. Prior to prescribing orthotics, I give a diagnosis based on case history, examination (physical, diagnostic, imaging, laboratory), including gait and postural analysis and interpretation and differential diagnosis to rule out possible pathologies | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 179. I obtain informed consent from patients prior to prescribing orthotics ¹⁸ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 180. I adhere to treatment protocol including: | | | | | |
| a) prescribing custom orthotics when they are required by the patient | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b) therapeutic trial of care with all orthotics | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

¹⁸ Refer to Section II (3) of this document.

| | | Never | Rarely | Sometimes | Usually | Always |
|------|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| | c) ensuring the orthotics dispensed meet the prescriptions of the contours of the patient's feet | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | d) providing short-term instructions and recommendations, reasonable expectations and advice on appropriate footwear | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | e) assessing the outcome of care to determine if there is a need for different treatment and/or referral to another health care provider | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 181. | The cost of orthotics reasonably relates to the time, expertise and cost of the orthotics | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 182. | I comply with CCO's conflict of interest standard with respect to the prescribing, manufacturing, selling and dispensing of orthotics, including: | | | | | |
| | a) I assure each patient that his/her choice of services or suppliers will not affect the quality of health care services provided by the member | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | b) I disclose if I have any personal interest in a supplier or company I use when prescribing, manufacturing, selling or dispensing orthotics | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

- | | Never | Rarely | Sometimes | Usually | Always |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| c) I inform each patient that he/she has an option of using any alternative facilities, services or suppliers | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Learning Objectives

Based on the above section (II,9), I will make changes to my practice.

- Yes No

Based on what I learned in this section, I will:

10. Conflict of interest in Commercial Ventures

- | | Never | Rarely | Sometimes | Usually | Always |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 183. I am familiar with and comply with Standard of Practice S-019: Conflict of Interest in Commercial Ventures | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 184. I disclose to patients any potential conflict of interest, including referral of a patient to a supplier of health care products and services in which I have a financial interest | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 185. I maintain the interests of my patients above my commercial interests | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Never Rarely Sometimes Usually Always

Learning Objectives

Based on the above section (II,10), I will make changes to my practice.

Yes No

Based on what I learned in this section, I will:

11. Assistive Devices

- | | | | | | | |
|------|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| | | Yes | No | | | |
| 186. | I am familiar with standard of practice S-021: Assistive Devices | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 187. | I prescribe or dispense assistive devices to my patients. <i>(If no, go to section 12)</i> | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| | | Yes | No | | | |
| 188. | I have appropriate training, skill and competence to examine, prescribe, sell and/or dispense assistive devices, as described in the standard of practice | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| | | Never | Rarely | Sometimes | Usually | Always |
| 189. | I use appropriate examination and diagnosis of patients with conditions within the scope of practice of chiropractic which may reasonably be expected to benefit from the use of assistive devices | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 190. | I evaluate indications and contra-indications of assistive devices for individual patients | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| | Never | Rarely | Sometimes | Usually | Always |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 191. Prior to prescribing orthotics, I give a diagnosis based on case history, examination (physical, diagnostic, imaging, laboratory), assessment of patient's physical and functional limitations, interpretation and differential diagnosis to rule out possible pathologies | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 192. I obtain informed consent from patients prior to prescribing assistive devices ¹⁹ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 193. I adhere to treatment protocol including: | | | | | |
| a) prescribing assistive devices when they are required by the patient | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b) therapeutic trial of care with assistive devices | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c) ensuring the assistive devices dispensed meet the prescriptions for that patient | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d) providing short-term instructions and recommendations, reasonable expectations and advice | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e) assessing the outcome of care to determine if there is a need for different treatment and/or referral to another health care provider | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

¹⁹ Refer to Section II (3) of this document.

| | Never | Rarely | Sometimes | Usually | Always |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 194. The cost of assistive devices reasonably relates to the time, expertise and cost of the assistive devices | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 195. I comply with CCO's conflict of interest standard with respect to the prescribing, manufacturing, selling and dispensing of assistive devices, including: | | | | | |
| a) I assure each patient that his/her choice of services or suppliers will not affect the quality of health care services provided by the member | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b) I disclose if I have any personal interest in a supplier or company I use when prescribing, manufacturing, selling or dispensing assistive devices | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c) I inform each patient that he/she has an option of using any alternative facilities, services or suppliers | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Learning Objectives

Based on the above section (II,11), I will make changes to my practice.

Yes No

Based on what I learned in this section, I will:

12. Best Practices

| | Never | Rarely | Sometimes | Usually | Always |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 196. I base patient care on best practices that reflect necessary care ²⁰ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 197. I put patients' interests ahead of my personal interests or financial gain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 198. I maintain forms that are consistent with CCO's standards of practice | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Learning Objectives

Based on the above section (II,12), I will make changes to my practice.

Yes No

Based on what I learned in this section, I will:

²⁰ For an explanation of best practices, please refer to page 15 of the Self Assessment Handbook.

III COMMUNICATIONS

| | Never | Rarely | Sometimes | Usually | Always |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 199. I identify myself as a chiropractor to my patients | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 200. I only use the title “doctor of chiropractic” | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 201. I only use the term “specialist” as outlined in policy P-029: Chiropractic Specialties – Fellow of the College of Chiropractic Sciences (Canada), Fellow of the Chiropractic College of Radiologists (Canada), Fellow of the College of Chiropractic Sports Sciences (Canada), Fellow of the College of Chiropractic Orthopaedic Specialists (Canada), Fellow of the Canadian College of Chiropractic Specialty College of Physical and Occupational Rehabilitation (Canada) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 202. I foster open, honest and clear communication that is understandable, meaningful and non-judgmental in all interactions with patients | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 203. I foster open, honest and clear communication that is understandable, meaningful and non-judgmental in all interactions with other health care providers | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 204. I foster open, honest and clear communication that is understandable, meaningful and non-judgmental in all interactions with CCO | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 205. I engage in effective communication with CCO in a timely manner | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| | Never | Rarely | Sometimes | Usually | Always |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 206. My written communication is clear and legible | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 207. I take into account all verbal, non-verbal and written communications | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 208. My communications are done in a timely and effective manner | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 209. My communications are done in a caring, professional and patient-centred manner | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 210. My communications take into account the language, socio-economic and cultural environment | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 211. I respect the dignity, value and trust of patients | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 212. I do not use religion, guilty, pressure tactics, or fear to coerce patients in starting or continuing care | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 213. I respect appropriate professional boundaries and avoid situations which could lead to boundary violations | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 214. I provide opportunities for patients to ask questions, seek clarification and give feedback | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 215. I maintain my office in a clean, organized and welcoming environment | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Learning Objectives

Based on the above section (III), I will make changes to my practice.

Yes No

Based on what I learned in this section, I will:

IV OFFICE POLICIES

1. Record Keeping

| | Never | Rarely | Sometimes | Usually | Always |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 216. I document all relevant findings obtained in section I, 1 to 7 (Patient/Doctor Interaction) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 217. I document both positive and negative findings in the patient file | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 218. I maintain my records in a clear and legible fashion, including maintaining an up-to-date short form legend, which can be made available to others. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 219. I make records contemporaneously (at the time of care) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 220. My notes accurately reflect all patient interactions | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 221. When requested to do so, I transfer records in a timely and effective manner | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 222. I maintain patient confidentiality | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| | Never | Rarely | Sometimes | Usually | Always |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 223. I ensure my staff maintains patient confidentiality | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 224. I maintain patient records in a confidential and secure manner | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 225. I understand that the information in the patient health record is the property of the patient and provide the patient with a copy in a timely manner upon request | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 226. I have agreements in place in my practice designating the ownership of records of personal care and arrangements for records upon dissolution of the practice ²¹ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Learning Objectives

Based on the above section (IV,1), I will make changes to my practice.

Yes No

Based on what I learned in this section, I will:

²¹ Refer to Standard of Practice S-022: Ownership, Storage, Security and Destruction of Records of Personal Health Information

2. Management and Financial Policies

| | Never | Rarely | Sometimes | Usually | Always |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 227. I disclose my fee schedule to patients prior to providing care | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 228. I disclose to patients the fee for a service before the service is provided, including a fee not payable by the patient | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 229. I only submit an account for services that I have provided to patients (following their consent) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 230. I do not have different fees for patients depending on third-party payors, unless the fee has been pre-negotiated with a third-party payor, such as the Workplace Safety and Insurance Board (WSIB), the Financial Services Commission of Ontario (FSCO) or a similar organization | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Yes | No | | | |
| 231. I use block fees in my office. <i>(If no, go to question 233)</i> | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 232. When charging a block fee/payment plan in my office: | | | | | |
| a) I ensure there is a signed, written agreement with the patient outlining the block fee/payment plan | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b) I give the patient the option of paying for each service as it is provided | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c) I specify an established block fee unit cost per service | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| | | Never | Rarely | Sometimes | Usually | Always |
|------|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| d) | I inform the patient of his/her right to opt out of the block fee-payment plan at any time | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e) | If the patient requests a refund, I refund the unspent portion of the block fee, calculated by reference to the number of services provided multiplied by the established block fee unit cost per service | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 233. | I itemize an account for professional services: | | | | | |
| a) | if requested to do so by the patient or the person or agency who is to pay, in whole or in part, for the services | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b) | if the account includes a fee for a product, device or service other than a care | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 234. | I have an up-to-date office manual that clearly outlines all office procedures and staff responsibilities. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 235. | I take full responsibility for all training and implementation of office policies and procedures by myself and all staff. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Learning Objectives

Based on the above section (IV,2), I will make changes to my practice.

Yes No

Based on what I learned in this section, I will:

3. Advertising

- | | Yes | No | | | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 236. I am familiar with standard of practice S-016: Advertising, guideline G-016: Advertising, and Policy P-016: Public Display Protocol | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 237. I currently advertise. <i>(If no, go to question 242)</i> | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| | Never | Rarely | Sometimes | Usually | Always |
| 238. My advertisements comply with the standard of practice S-016: Advertising. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 239. I submit my proposed advertising/marketing materials to CCO's Advertising Committee for review before publication. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Yes | No | | | |
| 240. I conduct public displays/health screenings. <i>(If no, go to section V)</i> | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 241. My public displays/health screenings comply with policy P-016: Public Display Protocol. | <input type="checkbox"/> | <input type="checkbox"/> | | | |

Learning Objectives

Based on the above section (IV,3), I will make changes to my practice.

Yes No

Based on what I learned in this section, I will:

V CONTINUING EDUCATION AND PROFESSIONAL DEVELOPMENT

| | Never | Rarely | Sometimes | Usually | Always |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 242. I participate in professional development activities (e.g., workshops, seminars, on-line learning) in the following areas of professional practice: | | | | | |
| a) clinical competency (including topics such as examination, diagnosis, radiology, patient care) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b) adjusting techniques, technologies, devices or procedures | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c) adjunctive techniques, technologies, devices or procedures (e.g., interferential current, ultrasound, laser, acupuncture, orthotics) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d) philosophy/communication | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| | Never | Rarely | Sometimes | Usually | Always |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| e) business practices | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f) ethics | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 243. I maintain an up-to-date professional portfolio that accurately reflects the following: | | | | | |
| a) continuing education participation in both structured and unstructured activities | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b) reflections on areas of strength and weakness in professional practice | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c) clear and time-limited implementation plans for improving on weaknesses | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 244. I participate in all CCO-mandated continuing education programs and initiatives | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 245. I remain current with CCO's requirement to maintain certification in emergency level first aid/CPR | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 246. I participate in at least 5 hours of structured CE related to the controlled acts authorized to chiropractors | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Learning Objectives

Based on the above section (V), I will make changes to my practice.

Yes No

Based on what I learned in this section, I will:

VI OBLIGATIONS TO CCO

- | | Yes | No |
|--|--------------------------|--------------------------|
| 247. I engage in effective communication with CCO in a timely manner. | <input type="checkbox"/> | <input type="checkbox"/> |
| 248. I immediately update CCO with any changes to my residential and business addresses and contact information | <input type="checkbox"/> | <input type="checkbox"/> |
| 249. I reply to CCO requests for information, such a response to a complaint, or a request for participating in a peer and practice assessment or other Quality Assurance initiative | <input type="checkbox"/> | <input type="checkbox"/> |
| 250. To date, I have participated in the following: | | |
| a) peer and practice assessment | <input type="checkbox"/> | <input type="checkbox"/> |
| b) record keeping workshop | <input type="checkbox"/> | <input type="checkbox"/> |
| c) x-ray peer review | <input type="checkbox"/> | <input type="checkbox"/> |
| 251. I complete my self assessment every two years | <input type="checkbox"/> | <input type="checkbox"/> |

252. I update my professional portfolio on the following basis: (choose one)

- | | | | |
|----|-------------------------------------|--------------------------|--------------------------|
| a) | as I complete a particular activity | <input type="checkbox"/> | <input type="checkbox"/> |
| b) | monthly | <input type="checkbox"/> | <input type="checkbox"/> |
| c) | every six months | <input type="checkbox"/> | <input type="checkbox"/> |
| d) | yearly | <input type="checkbox"/> | <input type="checkbox"/> |
| e) | every two years | <input type="checkbox"/> | <input type="checkbox"/> |

Learning Objectives

Based on the above section (VI), I will make changes to my practice.

Yes No

Based on what I learned in this section, I will:

CONCLUSION

You are now ready to complete the Self-Assessment Plan of Action Summary Sheet. Completed samples are provided in the Self-Assessment Handbook.