



ACORN PRACTITIONER QUESTIONNAIRE

Chiropractic practitioner characteristics

Q1 What is your age in years?

Q2 What is your gender?

- Male
 Female

Q3 Are you currently in private chiropractic practice?

- No
 Yes, how many years?

Q4 What is the highest level of chiropractic professional qualification that you hold?

- Diploma Masters degree
 Advanced Diploma PhD
 Bachelor (or Double Bachelor) degree
 Doctor of Chiropractic

Q5 Are you a member of any of the following professional chiropractic organisations? (select all that apply)

- CAA CAA and COCA
 COCA None
 Other(s) (Please specify)

Q6 Indicate all the roles in which you have been involved as a chiropractor over the last 12 months: (select all that apply)

- University teaching
 Research
 Clinical supervision
 Volunteer work
 Private practice
 Professional organisation activities

Q7 Do you routinely consult patients in a language other than English?

- No
 Yes (Please specify)

Practice characteristics

Q8 How many of the following would you provide on average, per week?

- a) Patient care hours
b) Patient visits

Q9 Do you practice in more than one location?

- No
 Yes, how many in total

Q10 Indicate all other health professionals working in your practice location(s): (select all that apply)

- GP Exercise Physiologist
 Podiatrist Psychologist/Counsellor
 Medical specialist Occupational Therapist
 Physiotherapist None
 Another Chiropractor Other(s) (Please specify)

Q11 Do you have a professional referral relationship (sending and/or receiving referrals) with any of the following practitioners: (select all that apply)

- GP Medical specialist
 Psychologist/Counsellor Exercise Physiologist
 Physiotherapist None
 Occupational Therapist Other(s) (Please specify)
 Podiatrist

Q12 In which state/territory do you practice? (select all that apply)

- NSW VIC QLD WA SA TAS NT ACT

Q13 Which of the following best describes your practice location(s)? (select all that apply)

- Urban Rural Remote

Q14 How frequently do you use diagnostic imaging as part of your practice?

- Never Rarely Sometimes Often

Q15 Indicate all imaging facilities or scanning tools you have on site: (select all that apply)

- X-ray Thermography
 MRI None
 SEMG Other(s) (Please specify)
 Diagnostic Ultrasound

Q16 Indicate when you use electronic records: (select all that apply)

- Initial History Examination findings
 Subsequent patient visits Never

Clinical management

Q17 Indicate the frequency with which you discuss the following as part of your care/management plans:

	Never	Rarely	Sometimes	Often
Diet / nutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smoking / Drugs / Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Activity / Fitness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Occupational Health and Safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain Counselling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nutritional Supplements (including vitamins, minerals, herbs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication (including for pain / inflammation)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (Please specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Q18 Indicate the frequency with which you treat patients that present with the following conditions:**

	Never	Rarely	Sometimes	Often		Never	Rarely	Sometimes	Often
Neck pain (axial)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Postural disorders (including lordosis, thoracic kyphosis, scoliosis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neck pain (referred/radicular)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Degenerative spine conditions (including spondylolisthesis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thoracic pain (axial)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headache disorders (including cervicogenic, tension)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thoracic pain (referred/radicular)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Migraine disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low back pain (axial)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spinal health maintenance/prevention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low back pain (referred/radicular)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Non-musculoskeletal disorders (Please specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lower limb musculoskeletal disorders (hip, knee, ankle, foot)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Upper limb musculoskeletal disorders (shoulder, elbow, wrist, hand)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (Please specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="text"/>				

Q19 Indicate the frequency with which you treat the following patient subgroups:

	Never	Rarely	Sometimes	Often		Never	Rarely	Sometimes	Often
Children (up to 3 years)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	People with work-related injuries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Children (4 to 18 years)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	People with traffic-related injuries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Older people (65 years or over)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	People receiving post-surgical rehabilitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aboriginal and Torres Strait Islander people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Non-English speaking ethnic group(s) (Please specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="text"/>				
Pregnant women	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (Please specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="text"/>				
Athletes or sports people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

Q20 Indicate the frequency with which you employ the following Techniques/Methods in your patient management:

	Never	Rarely	Sometimes	Often		Never	Rarely	Sometimes	Often
Drop-piece techniques / Thompson® or similar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Applied Kinesiology® (AK)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Biomechanical pelvic blocking / Sacro-Occipital Technique®	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Flexion-distraction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Instrument adjusting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Functional Neurology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chiropractic BioPhysics®	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Extremity manipulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High velocity, low amplitude adjustment / manipulation / mobilisation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other technique or intervention (Please specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="text"/>				

Q21 Indicate the frequency with which you employ the following Musculoskeletal Interventions in your patient management:

	Never	Rarely	Sometimes	Often		Never	Rarely	Sometimes	Often
Dry needling or Acupuncture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Orthotics (foot care)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soft tissue therapy, trigger point therapy, massage therapy, stretching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Specific exercise therapy / rehabilitation / injury taping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Electro-modalities (TENS, laser, interferential/ultrasound therapy)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (Please specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="text"/>				
Heat / cryotherapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					