



6470 East Johns Crossing
Suite C-170
Duluth, GA 30097
Phone: (800) 669-8682
Fax: (888) 774-0456

PROVIDER QUESTIONNAIRE

- ⇒ Please type or print all responses
- ⇒ Please include a curriculum vitae/resume with this questionnaire
- ⇒ Return the questionnaire, curriculum vitae/resume, and all attachments to the above address
- ⇒ Schedule of Office Hours
- ⇒ Usual and Customary Fee Schedule

We strongly recommend that you keep copies of all credentialing documents for your files

COMPREHENSIVE HEALTH GROUP is HIPAA compliant. CHG and its staff will treat this provider questionnaire and all information provided with the strictest confidence and will employ safeguards to protect the provider's privacy.

EDUCATION

Pre-Professional College – or attach curriculum vitae

City State Zip Code

Degree Major Attended: From (MMYY) To (MMYY)

Chiropractic College

City State Zip Code

Degree Attended: From (MMYY) To (MMYY)

Internship: Institution/clinic Name/D.C.

City State Zip Code

Program Director Attended: From (MMYY) To (MMYY)

Post-Graduate Education (Use additional sheets if necessary) Course	Location	Sponsor	Hours

Licenses: State License Number (LIST ON ADDITIONAL SHEETS IF NECESSARY) Expiration (MMYY)

List all Diplomates Attained Date Attained (MMYY)

Professional Society Memberships/Fellowships

TECHNIQUES

Please identify each technique used in your practice and indicate the percentage of usage.

Technique	%	Technique	%	Technique	%
Activator		Life Upper Cervical		Pierce-Stillwag	
Applied Kinesiology		Logan Basic		S.O.T.	
Barge		Meric		Thompson	
B.E.S.T.		N.E.T.		Toftness	
Cox (Distraction)		N.O.T.		Van Rumpft	
Cranial		Nimmo (Tonus)		Other _____	
Diversified		Nucca		Other _____	
Gonstead		Palmer/H.I.O.		Other _____	
Grostatic		Pettibon		Other _____	

PHYSICAL THERAPY MODALITIES

Please identify each physical therapy modality used in your practice and indicate the percentage of usage

Modality	%	Modality	%	Modality	%
Bed Rest		Massage Therapy		Vibrat Therapy	
Bracing		Orthotics/Lifts		Whirlpool Therapy	
Exercises		Ultrasound		Other _____	
Cryotherapy		Electrical Stim		Other _____	
Diathermy		Classical Traction		Other _____	
Hydrocollation		Direct Current		Other _____	
Infrared		Paraffin		Other _____	
Interferential		Ultraviolet		Other _____	

MISCELLANEOUS PRACTICE INFORMATION

Please list all languages spoken in your practice

Please indicate additional health care specialties available in your practice:

Other _____

Other _____

Other _____

Other _____

REFERENCES

Name three (3) individuals who have personal knowledge of your current clinical abilities, ethical character, and ability to work cooperatively with others and who will provide specific written and/or oral comments on these matters upon request from Comprehensive Health Group. *Do not include individuals with whom you have a direct business and professional relationship (e.g. practice partners).*

Name Telephone

Street Address

City State Zip Code

Name Telephone

Street Address

City State Zip Code

Name Telephone

Street Address

City State Zip Code

If you have any questions concerning the completion of this application, please call the Comprehensive Health Group Credentialing Coordinator at (800)669-8682.

I certify that all information given by me to the foregoing questions and statements in this questionnaire is true and correct without omissions of any kind.

Provider Name

Provider Signature

Date (MMDDYY)