Standards for High-Quality Chiropractic Care

The following standards reflect the expert Delphi consensus on delivering high-quality, safe, and patient-centered chiropractic care. (1)

INTAKE	
Provide timely access to care through appropriate scheduling systems.	
Obtain a documented past health history prior to initiating care.	
Obtain a condition-specific history relevant to the presenting complaint.	
Document current medications, including opioid use when applicable.	
Perform a review of systems relevant to the patient's presentation.	
Screen for psychological and social risk factors that may influence outcomes or chronicity.	
Screen for tobacco use and physical activity level when relevant to care.	
Obtain informed consent prior to examination and treatment.	
Ensure cost transparency for services provided.	

EXAMINATION & DECISION-MAKING	
Record vital signs when clinically appropriate.	
Perform a problem-focused clinical examination of the body region(s) to be treated.	
Screen for signs and symptoms of serious pathology (red flags).	
Assess baseline functional status and/or symptom severity using valid outcome measures.	
Use diagnostic imaging only when clinically indicated and consistent with best-practice guidelines.	
Screen for pregnancy prior to obtaining radiographs when applicable.	
Identify patients requiring referral or co-management due to findings outside the scope of chiropractic care.	
Identify patients at risk for self-directed violence and initiate appropriate referral pathways.	

CARE PLANNING & INITIAL TREATMENT	
Establish a current care plan based on clinical findings.	
Explain the suspected condition, evaluation process, and proposed next steps in a manner the patient understands (report-of-findings).	
Involve the patient in shared decision-making regarding care options.	
Define clear therapeutic goals for the episode of care.	
Provide education about the condition, including pain mechanisms when appropriate.	

CARE PLANNING & INITIAL TREATMENT	
Promote self-management strategies to support patient independence (home care and ADLs).	
Incorporate active care strategies, including supervised or unsupervised exercise.	
Incorporate manual therapies when clinically indicated.	
Encourage patients to remain active, particularly in cases such as low back pain.	
Deliver care only to body regions that have been evaluated.	

ONGOING CARE & REASSESSMENT	
Regularly assess the patient's response to prior care and evaluate the ongoing need for additional visits.	
Reassess functional and/or symptom outcomes using valid outcome measures at appropriate intervals.	
Modify the care plan based on objective findings, patient response, and clinical judgment.	
Support continuity of care, when possible, by maintaining the same provider during a care plan.	
Monitor for and document adverse events or unexpected responses to care.	

DISCHARGE & REFERRAL	
Use reassessment findings to inform continued care, discharge, or referral decisions.	
Refer or co-manage with other healthcare professionals, including pathways for psychological, social, and mind-body resources when clinically indicated and authorized by the patient.	
Systematically collect patient-reported feedback regarding care experience and satisfaction.	

SPECIAL CONSIDERATIONS	
Routinely screen older adults for osteoporosis risk, functional independence, and fall risk, provide evidence-informed guidance on balance, strength, and endurance exercises to reduce fall and fracture risk, and refer patients with suspected or confirmed osteoporotic fractures to appropriate medical providers.	
Implement infection control and prevention protocols, including staff training in hand hygiene, PPE, and environmental cleaning.	

Reference: *Vining R, Twist E, Minkalis A, Kleppe M, Kedilaya S. A Delphi panel consensus study validating the appropriateness, relevance, and clarity of quality measures for chiropractic care. BMC Health Services Research. 2025 Dec 16;25(1):1600. Link*