

Patient's Name \_\_\_\_\_

Occupation \_\_\_\_\_

Date \_\_\_\_\_

## Chiropractic Testimonial

Tell your story about how chiropractic helped you regain, obtain, and enjoy life and health more abundantly! Remember, your story may help others achieve the level of health that all of us want and deserve.

1. What health problems were you having that caused you to seek treatment in our office? \_\_\_\_\_

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2. Are your problems the result of an auto accident, a fall, emotional/psychological stress, or any specific incident? \_\_\_\_\_

Describe how it began \_\_\_\_\_

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3. How long have you had and lived with these problems? \_\_\_\_\_

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4. Please state how this condition altered and affected your daily life activities. \_\_\_\_\_

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5. Please list all the Physicians or Specialists (Medical Doctors, Chiropractors, Osteopaths, Acupuncturists, etc.) you have consulted for this condition and any successes, or failures in helping you regain your health.

Doctor's Name \_\_\_\_\_ Specialty \_\_\_\_\_

Treatment \_\_\_\_\_

Doctor's Name \_\_\_\_\_ Specialty \_\_\_\_\_

Treatment \_\_\_\_\_

Doctor's Name \_\_\_\_\_ Specialty \_\_\_\_\_

Treatment \_\_\_\_\_

6. How did you find out about our office? \_\_\_\_\_

7. When did you initiate care in our office? \_\_\_\_\_

8. Who is your Doctor in the office? Any comments about that doctor? \_\_\_\_\_

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\_\_\_\_\_  
\_\_\_\_\_

9. Describe your results and/or changes that have taken place since you began care, they may be related or unrelated to your initial condition. \_\_\_\_\_

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\_\_\_\_\_

10. If your family receives care in our office, please comment on the changes you have noticed since initiating care. \_\_\_\_\_

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11. Any additional comments about the advanced techniques used in our office, the exercise program, the spinal care classes, the educational programs, the staff, or anything you would like to say that may help others in their journey to better health. \_\_\_\_\_

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I hereby testify that my testimonial concerning my health condition is true and accurate, to the best of my knowledge, and release this information, along with my photograph to be used in part, or in it's entirety, for the purpose of this office patient education, or any other type of advertising, including but not limited to, direct mail, newspaper, etc. by Francis Chiropractic.

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Date