PLEASE TELL US ABOUT

YOUR EXPERIENCE

PATIENT TESTIMONIAL FORM

DURANT CHIROPRACTIC CLINIC, PC
902 5TH STREET, BOX 715
DURANT, IA 52747
563-785-6511
www.durantchiropractic.com

WHAT WAS YOUR CHIEF PHYSICAL COMPLAINT OR REASON FOR BEING SEEN IN THIS OFFICE?

_____

_____

HOW DID YOU FIND OUT ABOUT CHIROPRACTIC, OUR OFFICE OR THE TREATMENT YOU RECEIVED?

_____

_____

HOW LONG WAS IT BEFORE YOU NOTICED AN IMPROVEMENT?

_____

_____

DID YOU NOTICE ANY **OTHER** CHANGES IN YOUR HEALTH AFTER YOU BEGAN CARE IN OUR OFFICE?

_____

_____

_____

WOULD YOU RECOMMEND CHIROPRACTIC TO OTHERS? YES_____ NO_____

PLEASE WRITE A BRIEF PARAGRAPH ABOUT YOUR EXPERIENCE HERE?

_____

_____

_____

_____

_____

FOR ACUPUNCTURE PATIENTS

WOULD YOU RECOMMEND ACUPUNCTURE TO OTHERS?

_____

_____

_____

IF YOU PARTICIPATED IN THE SMOKING CESSATION ACUPUNCTURE PROGRAM PLEASE DESCRIBE YOUR RESULTS

_____

_____

_____

Testimonial release

I,_____give my authorization to Durant Chiropractic Clinic, PC, to use my testimonial for advertising, marketing and/or promotional activities, as well as to share with other individuals as the doctor sees fit. I also acknowledge that I am not being compensated for this testimonial either through monetary or monetary-equivalents. I verify I am at least 18 years of age.

Signature_____Date_____

Printed Name_____

Address and Phone_____