



Patient Testimonial Form

Do you have a Facebook account? Yes No
Do you have a Gmail account? Yes No

PLEASE TELL US ABOUT YOUR EXPERIENCE

What was your chief physical complaint or reason for being seen in our office?

What improvement(s) have you experienced in regards to your chief complaint?

What other changes to your health have you noticed since beginning care in our office (better sleep, more energy, feeling stronger, improved mood, less sickness)?

Would you recommend chiropractic to others?

Please write 2-3 sentences describing your experience with chiropractic in our office:

FOR ACUPUNCTURE PATIENTS

Please describe your experience and what benefits you noticed:

If you participated in the Tobacco Cessation Acupuncture program, please describe your results:

Testimonial Release

I, _____ give my authorization to Durant Chiropractic Clinic 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 through monetary-equivalents. I verify I am at least 18 years of age.

Durant Chiropractic Clinic may/ may not use my first name when sharing my testimony via any of the above-mentioned methods.

Signature: _____ Date: _____

Printed Name: _____