PATIENT TESTIMONIAL QUESTIONNAIRE

PATIENT'S FULL NAME: _____ D.O.B. _____

DATE ADMITTED TO CLINIC _____ TODAY'S DATE _____

OCCUPATION _____

HOW WAS PATIENT REFERRED TO CLINIC? _____

WHEN DID PATIENT FIRST BECOME SICK? _____

WAS PATIENT IN PAIN WHEN ADMITTED? _____

DESCRIBE FULLY PATIENT'S ACHES AND PAINS, ILLNESSES AND HOW THEY

AFFECTED THE DAILY LIFE OF PATIENT _____

_____

_____

_____

_____

_____

PREVIOUS METHODS OF TREATMENT: MEDICATION? _____

INJECTIONS? _____ SURGERY?(IF SURGERY GIVE NUMBER OF OPERATIONS AND

DETAILS.) _____

_____

_____

_____

_____

_____

WHAT WERE RESULTS OF PREVIOUS METHODS? _____

_____

_____

HAS POOR HEALTH CAUSED PATIENT TO LOSE TIME FOR WORK? _____

_____

HOW LONG UNDER CHIROPRACTIC CARE BEFORE PATIENT IMPROVED?_____

_____

DESCRIBE IMPROVEMENTS IN PATIENT'S CONDITION AND HOW THEY ENABLED PATIENT TO LEAD A BETTER, MORE USEFUL LIFE._____

_____

_____

_____

HAS PATIENT BEEN RELIEVED OF PAIN?_____ FEEL CURED?_____

BENEFITS RECEIVED THROUGH CHIROPRACTIC CARE _____

_____

_____

PATIENT'S GENERAL CONDITION NOW _____

_____

WHAT COMPLAINT REMAINS, IF ANY?_____

_____

_____

SIGNATURE: _____