Tell Us What You Think

PATIENT TESTIMONIAL FORM

Potomac Family & Sports
CHIROPRACTIC CENTER
21351 Gentry Dr., Suite 125 • Sterling, Va 20166
703-406-8686 • www.dr-alex.com

WHAT IS/WAS YOUR CHIEF MEDICAL OR PHYSICAL COMPLAINT?

_____
_____
_____

HOW DID YOU FIND OUT ABOUT CHIROPRACTIC?

_____
_____

WHAT ARE YOUR HEALTH PROBLEMS?

_____
_____
_____

DO THEY INTERFERE WITH YOUR DAILY ROUTINE? IF SO, PLEASE GIVE A BRIEF DESCRIPTION HOW.

_____
_____

HOW LONG WAS IT BEFORE YOU NOTICED AN IMPROVEMENT?

_____
_____

WERE THERE ANY OTHER CHANGES IN YOUR HEALTH AFTER YOU BEGAN THE PROGRAM BY YOUR DOCTOR?

_____
_____
_____

WOULD YOU RECOMMEND CHIROPRACTIC CARE TO OTHERS?

_____

PLEASE WRITE A BRIEF PARAGRAPH ABOUT YOUR EXPERIENCE HERE:

_____
_____
_____
_____
_____
_____
_____
_____

WOULD YOU MIND IF WE USED YOUR TESTIMONIAL FOR MARKETING PURPOSES? ❑ Yes ❑ No

Testimonial Release

I, _____ (name of patient), give my authorization to *Potomac Family & Sports Chiropractic Center* 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. Must be 18 years or older to authorize.

Signature: _____ Date: _____

Name (print): _____

Address: _____