Patient Testimonial Questionnaire

Name: ________________________________ Age: ________ Today's Date: ________________

Date of 1st Visit: _______________ Are your spouse and children patients? Y N

Occupation: ________________________ Do you sit / stand / lift / drive (please circle) ?

Who referred you to our office? ____

Please describe your previous symptoms: ____

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When did these problems start? ____

How did this affect your daily life? ____

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____

What treatments did you try first? Medication / Injections / Surgery / Physical Therapy

Other: ____

What were the results of previous methods: ____

____

How has chiropractic helped you? ____

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How long did it take before you noticed progress? ____

Were you able to decrease medication use? ____

Has Chiropractic care improved your quality of life? ____

Are you healthier now than you were a year ago? ____

What complaint remains if any? ____

Were you hesitant about chiropractic prior to beginning care? ________________________________

My signature will give permission to Scoles Family Chiropractic to use any or all of the facts in this questionnaire (including my photograph) in any way they see fit.

Signature ____ Date ________________________