


PRIMARY CARE
CHIROPRACTIC

C E N T E R

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Thank you for your interest in submitting a testimonial. Before we can share your wonderful information with our web visitors and other prospective clients, we must have on file a signed copy of this form.

Please complete this form and return it to Primary Care Chiropractic Center. Once we have received your completed form, we can then publish your story on our website, and in any other informational materials to which we feel your story will contribute (pamphlets, brochures, etc.). Your name will appear as "First Name, Last Initial" (i.e. Lori B.) on any materials on which it is included.

We respect your privacy and will not distribute any personal information (last name, address, phone, email, etc.) to any third party.

Thank you so much for your contribution!

I, _____, give Dr. Russell Radican and Primary Care Chiropractic Center permission to use my testimonial in marketing and informational materials, including their website.

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Date of Birth: _____

Signature: _____ Date: _____

Testimonial Questionnaire

Date: _____

1. Please tell us what condition was bothering you when you began care. _____

2. How often did this condition bother you? _____

3. How long had you had this condition? _____

4. What other type(s) of treatment had you tried prior to coming here? _____

5. What activities (work, hobbies, etc.) were you unable to perform? _____

6. How had treatment with Dr. Radican helped your condition? _____

Please share any additional comments. _____

First Name: _____ Last Initial: _____ Age: _____