Testimonial Form for BOC Website

email: info@bellinghamDO.com

Your testimonial may be printed on our website and shared to the public; however we will not disclose your personal name or contact information in accordance with HIPAA regulations.

The following information is for public records:

Include my first name and first letter of my last name with my testimonial? YES / NO

(IF NO is circled we will list you as –Anonymous)

What body region(s) did you come in to get treatment for *(circle all that apply):*

Head Neck Upper Back Lower Back Chest Shoulders Pelvis/Hips Sacrum

Arms/Legs/Hands/Feet/Wrists/Ankles Other: _____

Rate on a scale of 10 = worst pain & 0 = no pain the following:

- Before your first treatment your *initial pain level* was: _____
- After treatment your *current pain level* is: _____

Which doctor do you see *(circle all that apply)?* Dr. Sharon Stanley / Dr. Keith Swan

How many treatments approximately did you have before you felt improvement? _____

Did you seek additional treatment from other doctors prior to coming in which were not successful? (If yes please list how many other treatments you had before coming in to our office). _____

_____

Please list in a brief paragraph your detailed issue and experience obtaining osteopathic treatment at our office. Specifically list what was healed, how much pain was reduced, and in what ways did you notice the treatment changing your condition(s). Please be as detailed and specific as possible.

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The following Information is for internal private use only (for questions regarding your testimonial):

Your Full Name:

Your contact Number: