Patient Testimonial

Name (optional):	
Age:	Gender:
Occupation:	Length of time as our patient:
Consent: By submitting this testimonial, I agree to allow _____[Healthcare Facility/Provider Name]_____ to use my responses for promotional purposes, including but not limited to, website content, social media, and marketing materials. I understand that my name may be used alongside my testimonial, but my personal information will be kept confidential unless otherwise specified.	
Signature:	Date:

1. What health issue or concern led you to seek treatment with us?
2. How did you hear about our healthcare services?
3. What made you choose our healthcare facility/provider over others?
4. Describe your experience with our healthcare team/provider.

5. What specific aspects of our services stood out to you during your treatment?

6. How would you rate the effectiveness of the treatment or care you received?

7. Have you experienced any improvements in your health since receiving treatment with us? If so, please describe.

8. How would you describe the overall atmosphere and environment of our healthcare facility?

9. Would you recommend our healthcare services to friends or family? If so, why?

10. Is there anything else you would like to add about your experience with us?