

Chiro-Custom-Mattress Questionnaire

We are proud to offer the industry's first mattress specifically designed to fit your patient and any special needs or requirements that your patient may have. Please answer the following questions. If you feel that any of the questions are not applicable to your patient's situation, leave these answers blank and they will not be factored. By signing at the bottom, you are confirming that you are giving a recommendation on behalf of your patient for this specially designed bed.

Doctor's Name: _____ Clinic: _____

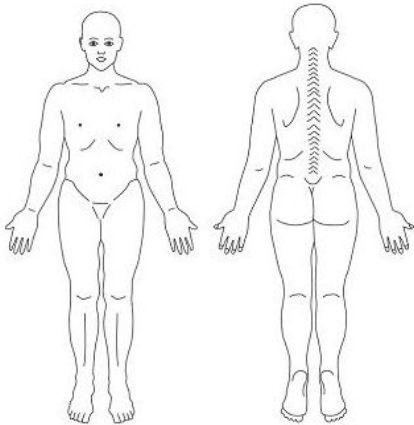
Telephone Number _____ Patient: _____

Patient's Height: _____ Weight: _____ Hip Circumference: _____ Shoulder Circumference: _____

Circle all that apply regarding the sleeping position preference of the patient:

- a. Back b. Side c. Stomach d. Two or more of these positions

Current Diagnosis or specific area of pain: _____



Write C for current and P for past on the figure below to denote the location of painful areas.

Please indicate any mattresses that your patient has researched, tested, lied on, or slept on and their feedback:

Approximate total budget allocated by patient for this purchase: \$ _____

Additional Comments: _____

Doctors Signature: _____ Date: _____

Fax to: 805 379-2309 ~ Questions about the Chiro-Sleeper program? Call Relief-Mart, Inc. at 800 667-1969