HALEY CHIROPRACTIC
For PEAK PERFORMANCE

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Medical Records

Name:_____ **Date:**_____

Date of Injury/Accident:_____

Please print

Attorney:

Address:_____

P:_____ F:_____

Facility:

o MRI_____ o XRAY _____ o C Scan_____

o Other:_____

Referral Doctor: _____

Date of Exam:_____

Address:_____

_____

P:_____ F:_____

Facility:

o MRI_____ o XRAY _____ o C Scan_____

o Other:_____

Referral Doctor: _____

Date of Exam:_____

Address:_____

_____

P:_____ F:_____

Facility:

o MRI_____ o XRAY _____ o C Scan_____

o Other:_____

Referral Doctor: _____

Date of Exam:_____

Address:_____

P:_____ F:_____

Physician:

Specialty:

Address::_____

_____

P:_____F:_____

Appt Dates:_____

Physician: ***Specialty:*** Address::____________________________________ ____ P:__________________F:____________________ Appt Dates:________________________________	***Physician:*** ***Specialty:*** Address::____________________________________ ____ P:__________________F:____________________ Appt Dates:________________________________
Physician: ***Specialty:*** Address::____________________________________ ____ P:__________________F:____________________ Appt Dates:________________________________	***Physician:*** ***Specialty:*** Address::____________________________________ ____ P:__________________F:____________________ Appt Dates:________________________________
Physician: ***Specialty:*** Address::____________________________________ ____ P:__________________F:____________________ Appt Dates:________________________________	***Physician:*** ***Specialty:*** Address::____________________________________ ____ P:__________________F:____________________ Appt Dates:________________________________

Patient Signature:____ **Date:__________________**