

Name: _____ Date of Accident: _____ Time: _____

Where did the accident happen? _____

Please describe the accident: _____

What type of vehicle were you in? _____ Your position ___ Driver ___ Passenger ___ Rear

Was your vehicle struck? _____ Did you strike another vehicle? _____ Headrest: ___ Up ___ Down ___ Unknown

Which direction were you looking at the time of impact? _____ Were you prepared for impact? _____

Was the vehicle struck from the ___ Front ___ Rear ___ Side (Driver/Pass.) ___ Angle

Was the brake applied? _____ Both hands on wheel? _____ Did the seat break? _____ Air Bag deploy? _____

Body position? ___ Leaning forward ___ Sitting upright ___ Arms locked ___ Other: _____

Were shoulder and lap belts in place? _____ Did you maintain consciousness _____

Did any part of your body strike anything? _____ Please specify: _____

How did you feel following the accident? _____

Were aid personnel on the scene? _____ Was aid rendered? _____ Ambulance transport? _____

Were you back boarded? ___ Collared? ___ Splinted? ___ Self transported _____

To which hospital? _____ Attended by which Dr.? _____

Were x-rays taken? _____ What was the ER diagnosis? _____

What did they do? _____

Were you ___ admitted or ___ released? What recommendations were made? ___ See own Dr., ___ See

Orthopedic Dr., ___ See Chiropractor, ___ Physical therapy, ___ Other: _____

Other caregivers seen about these injuries? ___ Who & when: _____

General Accident Information:

Was the accident "on-the-job"? _____

Your estimated speed at the moment of collision? _____

___ Stopped ___ Slowing ___ Accelerating

Other vehicle(s) [year, make, model] _____

Road condition: ___ Dry ___ Damp ___ Wet ___ Snow

___ Ice ___ Other: _____

Light: ___ Day ___ Night ___ Dusk ___ Dawn

Police? _____ Citation(s) _____ Report? _____

Which agency ___ State ___ County ___ Local

Accident Diagram:

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's name: _____ Date of Birth: _____

SSN: _____

I request and authorize **Mark A. Burick, D.C.** to release health care information of the patient named above to:

Name: _____

Affiliation: _____

Address: _____

This request and authorization applies to:

_____ Health care information relating to the following treatment, condition, or

dates of treatment: _____

_____ All health care information

_____ Other: _____

I understand that my express consent is required to release my health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment.

Signature of patient or patient's authorized representative

Date signed

Relationship or status if signed by anyone other than patient
(parent, legal guardian, personal representative, etc.)

THIS AUTHORIZATION EXPIRES ONE (1) YEAR FROM THE DATE IT IS SIGNED.