DR. RICHARD SKRILL
DR. GABRIEL SKRILL
3984 N. CAMPBELL AVE.
TUCSON, AZ 85719
PH: 520-321-1171 FAX: 520-321-1183

Dear Patient: This information is considered confidential. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. Please answer all questions completely. Thank you.

DATE _____

NAME _____ SOC. SEC #_____

ADDRESS_____ CITY_____ STATE_____ZIP _____

DATE OF BIRTH _____

HOME PHONE _____ CELL PHONE _____

OCCUPATION _____

EMPLOYER _____ WORK PHONE _____

EMAIL _____

Person to Contact in case of Emergency _____ Phone # _____

REFERRED BY:
____ FRIEND/ACQUAINTANCE _____
____ DR. _____ ____INS COMPANY PROVIDER MANUAL
____ ADVERTISEMENT _____ YELLOWPAGE _____ SAW WHILE DRIVING BY

Are you insured? ____ Yes _____ No

INSURANCE INFORMATION

Name of Person Responsible For Payment _____
PRIMARY INS. CO _____ POLICY # _____
SECONDARY _____ POLICY # _____
PRIMARY CARDHOLDER _____ DATE OF BIRTH _____
EMPLOYER _____

I UNDERSTAND AND AGREE THAT HEALTH AND ACCIDENT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN AN INSURANCE CARRIER AND MYSELF. FURTHERMORE, I UNDERSTAND THAT THE DOCTOR'S OFFICE WILL PREPARE ANY NECESSARY REPORTS AND FORMS TO ASSIST ME IN MAKING COLLECTIONS FROM THE INSURANCE COMPANY AND THAT ANY AMOUNT AUTHORIZED TO BE PAID DIRECTLY TO BE PAID DIRECTLY TO THE DOCTOR'S OFFICE WILL BE CREDITED TO MY ACCOUNT ON RECEIPT. HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR THE PAYMENT AS WELL AS ANY ADDITIONAL CHARGES WHICH MAY BE INCURRED BY DR. SKRILL PURSUANT TO THE COLLECTION OF MY ACCOUNT.

PATIENT'S SIGNATURE _____ DATE _____

GUARDIAN OR SPOUSE'S SIGNATURE AUTHORIZING CARE _____

PLEASE RETURN ALL FORMS TO THE RECEPTIONIST WHEN

RICHARD L. SKRILL D.C. M.S., M.Ac.
GABRIEL SKRILL D.C. FIAMA
3984 N. Campbell Ave
Tucson Az, 85719
Ph 520-321-1171, Fax 520-321-1183

Dr. Skrill and his staff is required by law to maintain the HIPPA Notice of Privacy Practices. This notice explains the legal duties and privacy practices with respect to your protected health information. Signature below acknowledges that I have read the posted Notice of Privacy Practices. A copy will be provided to me upon my request.

Printed Name _____

Patient Signature _____ Date _____

Witness _____ Date _____

Acknowledgement and Agreement:
Patient's Protocol For Records Preservation

I _____, patient of Dr. Skrill do hereby acknowledge and understand the doctor's protocol for the preservation of patient records. I agree to inform Dr. Skrill's office of any address changes and acknowledge that all requests for records, either by me or my representatives, must be in writing. I agree that the doctor's office may comply with all statutory notification requirements to me by regular mail to my indicated address, which is on file at this office.

Patient Signature _____ Date _____

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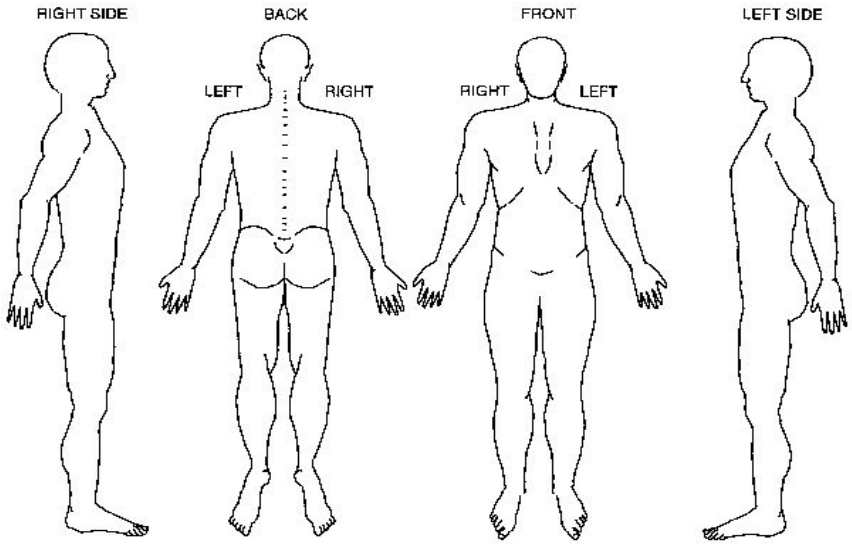
PLEASE INDICATE AREAS WHERE YOU ARE HAVING SYMPTOMS

Please list EACH complaint that you would like the doctor to know about. It is very important to answer completely. If you need more space to list additional complaints, please notify the receptionist.



SYMPTOM/COMPLAINT	SEVERITY (Circle)	Frequency (Circle)	ONSET
1)_____	Slight, Mild, Moderate, Severe	Occasional, intermittent, Frequent, Constant	_____
2)_____	Slight, Mild, Moderate, Severe	Occasional, intermittent, Frequent, Constant	_____
3)_____	Slight, Mild, Moderate, Severe	Occasional, intermittent, Frequent, Constant	_____
4)_____	Slight, Mild, Moderate, Severe	Occasional, intermittent, Frequent, Constant	_____

Please feel free to elaborate on any of the above symptoms:_____

_____

What Makes Symptoms Better? _____ Worse? _____

Type of Pain (CIRCLE) SHARP BURNING STABBING ACHING OTHER _____

Does This Pain Radiate or Travel? _____

Is Your Pain Worse At Any Particular Time of Day or Night? _____

Do You Wake Up At Night Because Of The Pain ☐YES ☐NO

Have You Suffered From This Or Similar Complaints In The Past ☐YES ☐NO
Please Describe _____

Have You Had FOUR Or More Episode of this pain in the past ☐YES ☐NO

Please Describe _____

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LIST OTHER PAST INJURIES INCLUDING BROKEN BONES, SERIOUS FALLS, AUTO ACCIDENT, ETC.:

_____

LIST ALL SURGERIES AND HOSPITALIZATIONS AND APPROXIMATE DATE _____

_____

WHAT OTHER HEALTH PROBLEMS DO YOU PRESENTLY HAVE THAT YOU ARE AWARE OF

_____

LIST ALL CURRENT MEDICATIONS _____

Have You Ever Taken Steroids Such as PREDNISONE For more than a Month ☐YES ☐NO

Have You Ever Taken Anticoagulants such as HEPARIN or COUMADIN For more than a Month ☐YES ☐NO

Do You Often Get Dizzy, Nauseous, Light-Headed, Or Blurred Vision upon turning your head ☐YES ☐NO

Date of Last Physical Exam _____ Family Physician's Name _____

HEALTH HISTORY

Has Anyone in Your Family Had Cancer, Heart Problems, Diabetes, Chronic Spinal Problems, Kidney Disorders, or Other Serious Illness? Father ☐YES ☐NO

_____

Mother ☐YES ☐NO

_____

Siblings ☐YES ☐NO

_____

Grandparents ☐YES ☐No

_____

PLEASE ANSWER THE FOLLOWING QUESTIONS AT YOUR OWN DISCRETION

Do You Smoke Cigarettes ☐YES ☐NO How Many Packs A Day _____
How Many Alcoholic Drinks Per Day? _____

Do You Exercise Regularly ☐YES ☐NO How Often?_____

Is Your Diet (Please Circle)
HIGH / LOW IN FIBER
HIGH / LOW IN CHOLESTEROL & SATURATED FATS
HIGH / LOW IN FRESH FRUITS AND VEGGIES
HIGH / LOW IN FAST FOODS OR JUNK FOOD

I AM INTERESTED IN TALKING TO THE DOCTOR ABOUT THE FOLLOWING

☐X-RAYS ☐HEALTH RISKS ASSOCIATED WITH TREATMENT
☐COSTS OF TREATMENT ☐ACUPUNCTURE
☐NUTRITION/DIET ☐EXERCISE/WEIGHT LOSS
☐OTHER _____

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INFORMED CONSENT AGREEMENT

Every type of health care is associated with some risk of a potential problem. This includes chiropractic health care. We want you to be informed about potential problems associated with chiropractic health care before consenting to treatment. This is called informed consent.

Chiropractic adjustments are the moving of bones with the doctor's hands or the use of a machine. Frequently, adjustments create a “pop” or “click” sound/sensation in the area being treated.

In this office all doctors are highly qualified, state and nationally certified chiropractic physicians who have graduated from nationally accredited chiropractic colleges. Occasionally, if your doctor is unavailable, another clinic doctor will be available to treat you that day if you so desire.

Stroke: Stroke is the most serious serious problem associated with chiropractic adjustments. Stroke means that a portion of the brain does not receive enough oxygen from the bloodstream. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death. Chiropractic adjustments have been associated with strokes that arise from the vertebral artery only. This is because the vertebral artery is actually found inside the neck vertebrae. The most recent studies (Journal of CCA, Vol. 37 No. 2, June 1993) estimate that the incident of this type of stroke is 1 per every 3,000,000 upper neck adjustments. This means that the average chiropractor would have to be in practice for hundreds of years before they would statistically be associated with a single patient stroke. Proper screening, which you will receive through your exam and history, should reduce the risk even further.

Disc Herniation: Disc Herniations that create pressure on the spinal nerve or on the spinal cord are frequently treated successfully by chiropractors and chiropractic adjustments. This includes herniations both in the neck and back. Yet, occasionally chiropractic treatment (adjustments, traction, etc.) will aggravate the problems if the disc is in a significantly weakened condition. These problems occur so rarely that there are no statistics to quantify the probability.

Soft Tissue Injury: Soft tissues primarily refer to muscles and ligaments. Muscles move bones, and ligaments limit joint movement. Rarely a chiropractic adjustment, tractions, massage therapy, etc., may tear some muscle or ligament fibers. The result is a temporary increase in pain and necessary treatment for resolution, but there are no long term effects for the patient. These problems occur so rarely that there are no available statistics to quantify the probability

Rib Fractures: The ribs are found only in the thoracic spine or middle back. They extend from your back to the front of your chest. Rarely a chiropractic adjustment will crack a rib or a bone, and this is referred to as a fracture. This occurs only on patients who have weakened bones from such things as osteoporosis. Osteoporosis can often be noted on your x-rays. We adjust all patients very carefully and especially those who are at risk for osteoporosis on their x-rays or medical history. These problems occur so rarely that there are no available statistics to quantify the probability.

Physical Therapy Burns: Some of the machines we use generate heat. We also use both heat and ice and recommend them for home care on occasion. Everyone’s skin has different sensitivity to these modalities, and rarely, either heat or ice can irritate the skin. The result is a temporary increase in skin pain, and there may even blistering of the skin. These problems occur so rarely that there are no available statistics to quantify the probability.

Soreness: It is common for chiropractic adjustments, traction, massage therapy, exercise, etc. to result in temporary increase in soreness in the region being treated. This is usually a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but please tell your doctor about it.

Other problems: There may be other problems or complications that might arise from chiropractic treatment other than those noted above. These other problems occur so rarely that that it is not possible to anticipate and/or explain them all in advance of treatment.

Chiropractic is a system of health care delivery, and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this clinic. We will always give you our best of care, and if results are not acceptable, we will refer you to another provider who we feel will assist your situation.

If you have any questions on any of the above, please ask your doctor. When you have a full understanding, please sign and date below

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PATIENTS NAME PRINTED TODAY’S DATE

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PATIENTS SIGNATURE PARENT OR GUARDIAN SIGNATURE FOR MINOR

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Medical Acupuncture Informed Consent

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of medical acupuncture on me (or on the patient named below, for who I am legally responsible). These procedures will be performed by Dr. Richard Skrill, Dr. Gabriel Skrill, or a licensed and accredited acupuncturist who is associated with the office.

I understand that the methods of treatment may include, but are not limited to, acupuncture, acupressure, massage, and use of activator. I have been informed that acupuncture is a safe method of treatment, but that it may have the rare side effects including bruising, numbness or tingling near needle site that may last a few days, dizziness, or fainting. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, organ puncture, pneumothorax, and infection. These unusual risks can be mitigated through the use of properly observed technique, precise needling, the use of sterile disposable needles, and having a clean and safe work environment. I understand that while this document describes major risks of treatment other side effects may occur.

I will immediately inform the doctor if I am or become pregnant or experience any unpleasant side effects. I do not expect the doctor to be able to explain all risks and complications of treatment, and I wish to rely on the doctor to exercise judgement during the course of treatment which based upon the known facts, is in my best interest. I understand that results are not guaranteed.

By voluntarily signing below I show that I have read, or have had read to me, this consent to treatment, have been told about the risk and benefits of acupuncture and other procedures, and have had the opportunity to ask questions. I intend this informed consent to cover the entire course of treatment for my present condition and any future conditions for which I seek treatment.

Patient Name _____

Patient Signature _____

Guardian SIgnature _____

Date Signed _____

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