MONSALVE
INTEGRATIVE HEALTH

Daniel Monsalve, D.C.
Office: 305-209-4731 Fax: 305-397-1520
6705 Red Road suite 702 Miami, FL 33143
Office@MonsalveChiropractic.com
www.Monsalvechiropractic.com

Name:	☐ Male ☐ Female	Today's Date:
Address:	City/State/Zip:	
Home Phone: ( )	Cell Phone: ( )	Work Phone: ( )
Age: Social Security#:	Date of Birth:	Marital: ☐ M ☐ S ☐ Other
Occupation:	Employer:	Name of Spouse:
Number of Children:	Ages of Children:	Email:
Insurance type: ☐ Health ☐ Medicare ☐ Medicaid ☐ Car accident ☐ Workers' Compensation ☐ Other		
Who may we thank for referring you to our office?		

Welcome to our office! Please complete all questions.

ARE YOU HERE FOR WELLNESS CARE OR FOR A SYMPTOM? ☐ Wellness ☐ Symptom

If you have a specific symptom(s), fill out this box and briefly describe each one in order of severity:

1. (Main complaint)_____
2. _____
3. _____
4. _____
5. _____

How long have you had your main complaint?_____

Have you ever had this before? ☐ Yes ☐ No When?_____

Was this related to: ☐ Auto Accident ☐ Work Accident

Have you lost work days? ☐ Yes ☐ No If so, how many?_____

HOW DO YOU WANT TO HANDLE THIS PROBLEM?

☐ Temporary relief (Help the symptom but don't fix the cause of the problem)
☐ Maximum correction (Correct the cause of the problem for maximum stability in the future)

(please turn over)

List drugs you are currently taking(prescription and non-prescription)_____

What surgeries have you had?_____

Is there any chance you are pregnant? □ Yes □ No

Have you ever been diagnosed with cancer? □ Yes □ No If so, what kind?_____

When did you last see a chiropractor?_____ Dr._____

What spinal maintenance programs were you given to maximize the future stability of your spine?_____

_____

Did you follow them? □ Yes □ No If not, was there a reason you didn't?_____

Why are you changing chiropractors?_____

PLEASE CHECK ANY OF THE FOLLOWING THAT GIVE YOU DIFFICULTY:

□ Headaches	□ Depression	□ Mid-back pain	□ Kidney trouble
□ Shooting head pains	□ Dizziness	□ Heart attacks	□ Menstrual cramps and pain
□ Sinus Troubles	□ Fainting	□ High blood pressure	□ Menstrual irregularity
□ Loss of smell	□ Loss of Balance	□ Low blood pressure	□ Diabetes
□ Allergies	□ Ringing in ears	□ Anemia	□ Cancer
□ Hay fever	□ Blurred vision	□ Stomach trouble	□ Sleeping problems
□ Ear Infections	□ Light bothers eyes	□ Nervousness	□ Painful joints
□ Asthma	□ Neck Pain	□ Inner tension	□ Swollen joints
□ Loss of taste	□ Muscle spasms in neck	□ Irritability	□ Pinched nerves in back
□ Tightness of throat	□ Tightness of shoulder muscles	□ Cold Sweats	□ Pins and needles in legs
□ Inflammation of throat	□ Pain in shoulders and arms	□ Gall bladder trouble	□ Swollen ankles
□ Thyroid trouble	□ Pins and needles arms/hands	□ Indigestion	□ Cold feet
□ Twitching of face	□ Cold hands	□ Intestinal gas	□ Pains in legs and feet
□ Loss of memory	□ Chest pains	□ Low back pain	□ Constipation
□ Fatigue	□ Pain when coughing	□ Numbness in the low back	□ Difficulty breathing
□ Lung problems	□ Frequent urination	□ Mental Disorders	□ Excess sweating
□ Stroke	□ Prostate problems	□ Dyslexia	□ Liver problems

Signature: _____ Date: _____

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Assignment of Benefits

I _____ hereby authorize Monsalve Integrative Chiropractic to bill my insurance carrier for all medical services rendered. I also authorize my insurance carrier to direct all medical payments directly to:

Monsalve Integrative Chiropractic Inc.
6705 Red Road Suite 702
Miami, FL 33143
NPI#: 1427477983
Tax ID#: 46-5391113

I also understand that should my insurance carrier send any medical payments to me directly, that I will forward all checks and explanation of benefits to Monsalve Integrative Chiropractic.

Signature

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I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) f)or which I seek treatment.

Patient Signature_____ Date _____

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Date:_____

I, _____ hereby authorize Monsalve Integrative Chiropractic to take any X-rays which are considered to be necessary for my case. I hereby certify that **I am not pregnant nor do I believe to be pregnant.**

I further understand that if I am pregnant and do not inform the Doctor, radiation could cause permanent health risks to the unborn child.

Furthermore, I understand that Monsalve Integrative Chiropractic **will not be held responsible** for any of these health problems or risks that my unborn child may suffer if **I do not inform** the doctor that I am pregnant or believe to be pregnant.