SCHEHR CENTER
FOR WELLNESS
Headache · Pain · Healthy Aging

9199 Reisterstown Road, Suite 203B
Owings Mills, MD 21117
410.665.3223

Patient Registration Form

Name: _____
Last First M.I.

Address:_____
Street City State Zip

Phone: (Home) _____ (Work) _____ (Cell) _____

Email: _____ Birthdate:_____ Male/Female _____

Marital Status: M _____ S _____ D _____ W _____

Emergency Contact: _____ Contact Phone: _____

Relationship to Patient: _____

Referring Physician: _____ Office Phone: _____

Please Check Yes or No Regarding Following Conditions/History

	Y	N		Y	N		Y	N
Smoke/ Chew Tobacco			Diabetes			Depression		
High Blood Pressure			Heart Attack			Osteoarthritis		
High Cholesterol			Cardiac Bypass			Rheumatoid Arthritis		
Bowel/Bladder Issues			Cardiac Stents			Osteoporosis or Osteopenia		
Seizures			Angina/Chest Pain			Metal/ Plastic Implants		
Asthma			Pacemaker			Dizziness		
Vision Impaired			Emphysema/COPD			Cancer		
Hearing Impaired			Stroke			Bleeding Disorders		

Any other medical conditions not listed above, please list: _____
_____

Are you or could you be pregnant? Yes: ___ If yes, number of weeks: ____ No: ____

Have you had surgery? Yes: ___ No: ___ If yes, list surgeries: _____
_____

Are you on any medications? Yes ___ No: ___ If yes, list: _____
_____

Please Check: I do ___, do not ___ permit Schehr Center for Wellness to leave messages with my family or co-workers regarding appointments or changes in schedule.

Signature: _____ Date:_____