BREAKTHROUGH PHYSICAL THERAPY, INC
SPORTS PERFORMANCE/ WELLNESS/ VIDEO ANALYSIS/ FMS
REGISTRATION FORM
(Please complete all questions)

OFFICE USE ONLY				
TREATING THERAPIST: ______________________	NP	RS	UPD	NBP

DATE __________ LAST NAME ________________________ FIRST NAME ________________ SEX ○ M ○ F

DOB ________________ AGE _____

ADDR ____ CITY ________________________ ST ____ ZIP ______

HOME PH # __________________ WORK PH # ___________________ CELL PH # ___________________

E-MAIL ADDRESS ____ STUDENT STATUS ○ FT ○ PT ○ NA

EMPLOYER ________________________________ EMPLOYMENT STATUS ___________

(Either patient or responsible party)

RESPONSIBLE PARTY NAME (IF MINOR): ____

RESPONSIBLE PARTY DOB _______________

ADDR ____ CITY ________________________ ST _____ ZIP _____

EMERGENCY CONTACT _________________________ RELATIONSHIP __________ PHONE # ______________

WHO MAY WE THANK FOR YOUR REFERRAL? ____

CANCELLATION & NO-SHOW POLICY: We require 24 hours notice in the event of a cancellation. The charge for cancellation without proper notice is $40. This charge will have to be paid by you personally prior to receiving additional treatment.

Patient Init. _________ Date: __________

RETURNED CHECK POLICY: Please be advised that our office charges a $20.00 administration fee for all returned checks.

Patient Init. _________ Date: __________

CONSENT FOR TREATMENT OF A MINOR: As parent and/or legal guardian, I authorize **BreakThrough Physical Therapy, Inc.** to treat the minor patient named in the attached forms while I am not present for todays and/or future scheduled appointments unless further written notice is provided by me to BreakThrough Physical Therapy, Inc.

Parent/Guardian Signature ____ **Date**______________

FINANCIAL POLICY ACKNOWLEDGEMENT: It is the client's responsibility to pay for all services prior to his or her session. This may be done each session or with the purchase of a discount package in advance.

Patient Init. _________ Date: __________

I HAVE READ ALL THE INFORMATION ON THIS REGISTRATION FORM. I CERTIFY THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY YOU OF ANY CHANGES IN MY HEALTH STATUS OR INFORMATION.

Participant's Signature	Participant's Name (please print)	Date
Signature of Parent/Guardian if Participant is not at least 18 years of age	Name of Parent/Guardian is Participant if not at least 18 years of age (please print)	Date
BreakThrough Representative's Signature	BreakThrough Representative's Name	Date

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Sunnyvale, CA 94086
(408) 736-7600 phone
(408) 736-7604 fax
breakthroughpt.com

FMS Intake Sheet

Client Name: ______________________________ **Date:** ______________

1) What is the primary reason for scheduling this FMS today?

2) What are your areas of interest (sports, hobbies, etc.)?

3) Do you have any Current/Prior Injury or Medical History information we should be aware of?:

4) Is there anything else you would like to include or discuss with your specialist?

Client Signature: ____