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

BreakThrough

MEDICAL HISTORY

Patient Name ______________________________ Age ________

Type of Injury / Condition ______________________________ Onset / Injury Date ________________

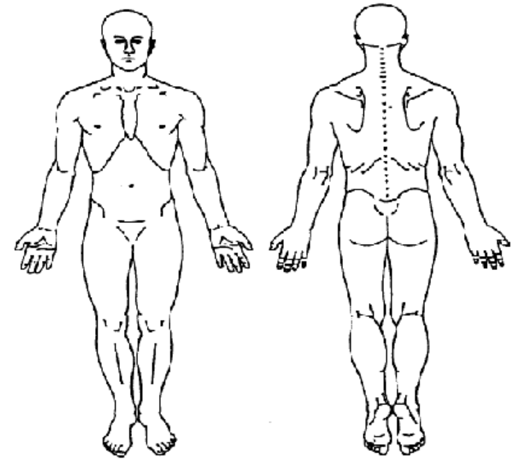
Occupation ______________________________

Sports Activities / Exercise ______________________________

Type of Surgery & Date ______________________________

Next Doctor's Appointment? ______________________________

Describe previous treatment for this condition



Please mark the area(s) of concern

Have you had any of the following tests:

- ☐ X-Ray
- ☐ MRI
- ☐ EMG
- ☐ CT Scan
- ☐ Doppler
- ☐ Ultrasound

What were the findings for the above?

Have you recently noted:

- ☐ Unexpected Weight Loss / Gain
- ☐ Weakness / Stumbling While Walking
- ☐ Changes in Bowel / Bladder Habits
- ☐ Pain at Night
- ☐ Difficulty Swallowing / Speaking
- ☐ Nausea / Vomiting / Dizziness
- ☐ Pain with Coughing / Sneezing
- ☐ Fainting
- ☐ Numbness / Tingling in the Saddle Area
- ☐ Numbness / Tingling in both Hands and Feet at the Same Time
- ☐ Fatigue
- ☐ Numbness / Tingling
- ☐ Change in Vision or Double Vision

Do you have now or have you ever had any of the following?

- ☐ Surgeries
- ☐ Sprains / Strains
- ☐ Heart Problems
- ☐ Circulation Problems / Clots
- ☐ Easy Bruising / Bleeding
- ☐ Pregnancy
- ☐ Loss of Consciousness
- ☐ Diabetes
- ☐ Cancer
- ☐ Asthma / Breathing Problems
- ☐ Indigestion / Heartburn
- ☐ Fractures
- ☐ Blood Pressure Problems
- ☐ Motor Vehicle Accident
- ☐ Osteoporosis / Osteopenia
- ☐ Allergies / Skin Sensitivity
- ☐ Any previous injury that may affect current care ______________________________

Explain & give approximate dates for any items indicated above

Are you currently taking medications? ◯ Yes ◯ No Name or Type of Medication ______________________________

Type Of Pain: ☐ Sharp ☐ Burning ☐ Aching ☐ Tingling ☐ Numbness ☐ Other ________________

Rate your pain (1=minimal 10=severe): At its worst ________________ At its best ________________

What are your personal or fitness goals?

Is there anything else you would like to include or discuss with your physical therapist?