BreakThrough PHYSICAL THERAPY

Patient Registration Form – Pediatric Patients (12 yrs and over)

Patient Name:	Date of birth:	
Preferred:		
Address, City, State, Zip:		
Parent/Guardian Information		
1st Parent/Guardian name:	Contact number:	
Address if different form above:		
2nd Parent /Guardian name:	Contact number:	
Address, if different from above:		
Home Phone: Work phone:		Appointment Reminder Method
Cell Phone:		☐ Home Phone ☐ Cell Phone/Text
Email address:		☐ Work Phone ☐ Email
2nd Contact name/address:		
2nd contact phone:	Relation:	
Pediatrician/Physician:	Referred by:	

INSURANCE INFORMATION Please Note: A copy of your insurance card(s) will be kept on file. The patient is responsible for providing their most current insurance information.

Primary Insurance:		Secondary Insurance:	
Group #	Policy #	Group #	Policy #
Insured Information:		Insured Information:	

Consent to Treat/Assignment of Benefits/Acknowledgements

I hereby authorize and consent to treatment/services for myself, or on behalf of the above-named patient performed by the staff at BreakThrough Physical Therapy (BTPT) and/or as directed by my referring provider. I understand that I have the right to ask and have any questions answered prior to receiving any treatment, including risk or alternatives to the recommended treatment plan.

I assign payment for these services directly to BTPT. I authorize the filing of claims to my insurance plan and authorize BTPT to release necessary health information related to these services to process the claims. I certify that the information I have provided is accurate and complete.

In signing this form, I will promptly pay any required co-pay, coinsurance and/or deductible amounts. I accept that insurance plans may deny payments for what I believe were covered services, resulting in my responsibility for paying for these services.

I acknowledge that I have received the Notice of Privacy Practices, which describes the ways the practice may use or disclose my healthcare information. I understand that my healthcare information may be used for treatment, payment, healthcare operations and other permitted uses or disclosures as described in the Notice.

_____ _____

Signature of Patient/Guardian Date

_____ _____

Print Name Relationship to the Patient

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Patient name:	DOB:

Authorization for Communication

By providing my above contact information and signing below, I consent and authorize BTPT and its related entities, agents, contractors, including but not limited to scheduling, billing, and other departments to use automated telephone dialing systems, SMS text messaging, (if opted in) and electronic mail to (1) provide messages (including prerecorded messages or text messages, (if opted in)) to me about appointment reminders, patient surveys, my account, payment due dates, missed payments, information for or related to medical goods and/or therapy services provided, exchange information, changes to health care law, health care coverage, care follow-up, and other healthcare information or (2) provide messages (including pre-recorded messages) during a call or via text message, (if opted in) that delivers a 'health care' message made by, or on behalf of, a 'covered entity' or its 'business associate' as those terms are defined in the HIPAA Privacy Rule, 45 CFR 160.103. I understand that providing a telephone number and/or email address is not a condition of receiving medical services.

I also understand that I may revoke my consent to contact at any time by directly contacting BTPT or using the opt-out method that will be identified in the applicable communication. I also understand that it is my responsibility to notify BTPT immediately of any change in telephone number or email address.

Please check the box below to opt in to receive messaging.

☐ **I consent** to receiving text messages about care, appointment reminders, and important health reminders From BTPT at the phone number I provided. I acknowledge that my consent is not a condition of purchase. Message & data rates may apply. Message frequency varies. You can reply HELP for support or STOP to opt out of receiving messages. To learn more about how we handle your data please view our privacy policy here.
https://breakthrough-pt.com/wp-content/uploads/sites/25/2026/03/BRPT-Website-Privacy-Policy-Terms-11-2025.pdf

☐ **I do not** consent to receiving text messages.

Patient/Guardian Signature: Date:

Release of Information

I hereby authorized BTPT to discuss my personal healthcare information regarding my treatment including diagnosis/prognosis and/or billing and payment for services rendered on my behalf to the person(s) listed below.

Name (print)	Relationship	Phone number
Name (print)	Relationship	Phone number
Name (print)	Relationship	Phone number

Patient/Guardian Signature: Date:

Patient name:	DOB:

Financial Policy

Payment for services is due at the time services are rendered.
We will verify your benefits with your insurance carrier. However, this does not guarantee that they will cover the prescribed treatment. By signing below, you are acknowledging that you are responsible for deductibles, copays, coinsurance, and non-covered services not paid by the insurance carrier and understand that you are fully responsible for any balance due for services rendered.

Patient/Guardian Signature: Date:

Cancellation/No Show Policy and Fee Acknowledgement

It is the policy of BTPT to monitor and manage appointment no-shows and late cancellations. Regular attendance at therapy sessions is crucial for you to recover fully and return to the activities you love. When an appointment is missed, it's a missed opportunity for progress in your recovery, and it impacts our ability to accommodate other patients who may need urgent care.

If you need to cancel or reschedule, please call the clinic.

Scheduled appointments must be cancelled or rescheduled at least 24 hours prior.

Failure to attend your appointment without 24-hour notice may result in a fee of $50 that will be charged directly to you as the patient (not insurance) for each instance of a missed appointment.

Patient/Guardian Signature: Date:

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Patient name:	**DOB:**
PEDIATRIC PATIENT HEALTH QUESTIONNAIRE	
Lives with both parents? ☐Yes ☐No If not, with whom does child live most of the time?	
Siblings - Name, ages, and any history of delays:	
Is this child: ☐ Biological ☐ Adopted	Height: Weight:
List any precautions you would like for us to know.	
Please list specialist/physicians seen, including dates, names, specialty.	
List any special tests (x-ray, MRI, etc.) including dates.	
Please list any known allergies (including medications, latex, etc.) below.	
Has your child had a vision test/screening? ☐Yes ☐No Date:	Results:
Please indicate if your child has had the following vaccinations **MMR:** ☐Yes ☐No **Hepatitis:** ☐Yes ☐No **Chicken Pox:** ☐Yes ☐No	

Surgery / Hospitalization, please include date and reason.	

Please list child's current medications (including prescription, over the counter, and herbal). You can also provide our office staff a list to copy.			
Name	Dosage	Frequency	Please Indicate Route
			Oral Patch Topical Other
			Oral Patch Topical Other
			Oral Patch Topical Other
			Oral Patch Topical Other

Educational History	
School:	Grade:
Please indicate your child's school schedule (i.e., days, times, etc.)	
Describe your child's school performance.	
What, if any, special services does your child receive at school?	

Patient name:	**DOB:**
Social and Other Information	
Interest/Hobbies.	
Describe peer relations.	
Describe your child's most concerning/challenging behaviors.	
Does your child have any textures they like or dislike?	
My child's fears are:	
What works to motivate or reward your child?	

Are you currently experiencing any of the following?			
Nausea or Vomiting	☐ Yes ☐ No	Chest Pains (Angina)	☐ Yes ☐ No
Productive/Chronic Cough	☐ Yes ☐ No	Pain Wakes Me at Night	☐ Yes ☐ No
Difficulty Swallowing	☐ Yes ☐ No	Recent Fever, Chills, Sweats	☐ Yes ☐ No
Dizzy Spells	☐ Yes ☐ No	Difficulty Sleeping	☐ Yes ☐ No
Headaches	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No
Visual Problems	☐ Yes ☐ No	Heart Palpitations	☐ Yes ☐ No
Hearing Loss/Ringing in Ears	☐ Yes ☐ No	Loss of Appetite	☐ Yes ☐ No
Difficulty Walking	☐ Yes ☐ No	Incontinence	☐ Yes ☐ No
Unusual Weakness	☐ Yes ☐ No	Fatigue or Myalgia	☐ Yes ☐ No
Joint Pain or Swelling	☐ Yes ☐ No	Unexplained Weight Changes	☐ Yes ☐ No

Has patient been diagnosed with any of the following?			
Allergies	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	HIV	☐ Yes ☐ No
Hepatitis, If Yes, Type:	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Respiratory Problems	☐ Yes ☐ No	Kidney Disease/Problems	☐ Yes ☐ No
Auto Immune Disease If yes, Type:	☐ Yes ☐ No	Spinal Cord Stimulator	☐ Yes ☐ No
Blood Clots	☐ Yes ☐ No	Vision Problems	☐ Yes ☐ No
Bowel or Bladder Disorder	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No
Cancer, If yes, Site:	☐ Yes ☐ No	Rheumatoid Arthritis	☐ Yes ☐ No
Cardiac Conditions	☐ Yes ☐ No	Parkinson's	☐ Yes ☐ No
Cardiac Pacemaker	☐ Yes ☐ No	Peripheral Vascular Disease	☐ Yes ☐ No
Currently Pregnant	☐ Yes ☐ No	Seizures	☐ Yes ☐ No
Depression	☐ Yes ☐ No	Speech Problems	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Hearing Loss	☐ Yes ☐ No
Stroke/TIA	☐ Yes ☐ No	Fractures	☐ Yes ☐ No

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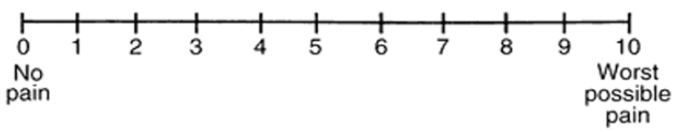
Patient name:	**DOB:**
Current Condition	
Describe the problem(s).	
Explain how problem(s) occurred.	
When did this problem(s) first begin/date of onset?	
Is the current condition related to recent surgery? ☐Yes ☐No If yes, specify date of surgery:	
Has your child ever had this problem before? ☐Yes ☐No If yes, how many times?	
Are the symptoms worse in the: ☐Morning ☐Afternoon ☐Evening ☐Night ☐Same All Day	
How are you taking care of the problem(s) now?	
Is child's pain/problem is slowing getting: ☐Worse ☐Better ☐Staying the Same	
Are child's symptoms: ☐Constantly (100%) ☐Most of the Time (75%) ☐Occasionally (50%) ☐Once in a While (25%)	
Is there any numbness, tingling, or burning? ☐Yes ☐No If yes, please check one: ☐ Constantly ☐Intermittently	
What functions could child perform before, but is unable to do now?	
Please explain any specific treatment you have received for this problem, such as previous physical or occupational therapy, chiropractic visits, pain medications, etc.	
Please list any developmental therapies or interventions your child has participated in or is currently participating in. Include dates. (OT, PT, SLT, music therapy, counseling, etc.)	
Are you aware of any physical reason why your child should not receive treatment? ☐Yes ☐No If yes, please tell us what it is:	
What are your goals for therapy for your child?	
What other information would you like for us to know about your child that would aid in their evaluation/treatment?	
Prioritize your top 3 concerns you want to be sure we address in this evaluation and/or therapy?	
1.	
2.	
3.	

Please rate your pain on a scale from 0 – 10 (0 = no pain; 10 = Worst pain imaginable)

Current: /10 Best: /10 Worst: /10



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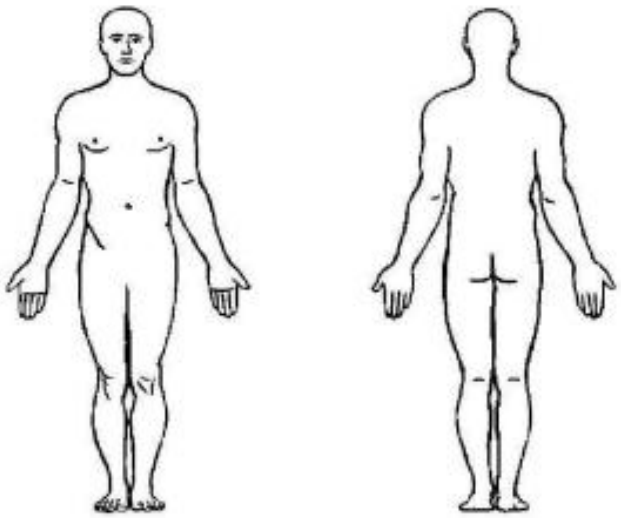
Patient name:	**DOB:**

Symptom Rating

Mark on the body diagram the location of symptom(s):

O - For pain
X - For numbness/tingling/burning



I certify the above information is correct to the best of my knowledge and will advise the therapist if there is any change in the information provided above.

Signature: _____ Date: _____

Clinician signature: _____ Date: _____