**Welcome to Brightside! I'm glad you're here.**

My name is Christina, and I am a licensed Doctor of Physical Therapy specializing in complex pain and pelvic health conditions. I founded Brightside because I believe that wellness is our natural state of being, and I wanted to create a space in which hope, healing, and restoration flow easily.

You're here because you have a problem that is preventing you from enjoying your life to the fullest, and you're wondering how I might be able to help.

Physical therapy is the art of tapping into the body's own powerful healing capabilities in order to relieve pain, optimize function, and improve quality of life throughout the lifespan. As a physical therapist, I have an intimate understanding of the physical structures and processes that participate in your activities of daily living. I will use scientific knowledge and evidence-based treatments to address your problem and help you build a "toolbox" of skills to take better care of yourself at home.

Physical therapy at Brightside is special in that I treat the "whole person" - I do not believe it is possible to address the physical body without considering the environmental, emotional, and spiritual aspects of each individual I work with. At Brightside, you will receive an integrative approach to treatment: this means that I will not only teach you exercises and stretches, but I will also help you understand how your body works, what's going on in your life that may be contributing to your symptoms, and what things you can do to create the changes you're looking for.

At Brightside, I believe our time together is special - I offer private 1:1 sessions so that you will always have my full attention during your scheduled appointment, and I schedule a maximum of one patient per hour so that we will always have ample time to do the work we need to do that day. In return, what I will ask from you is honest communication, consistent participation, and openness to the idea that change is possible.

As you will hear me say many times during our process, the path to healing is made up of *baby steps in the right direction*. If you are ready to get stronger, feel better, and get to know your body in a whole new light, then you have already taken the first step.

Thank you for choosing Brightside - I am so happy to begin working with you.

Dr. Christina Jensen PT, DPT

## Informed Consent

Participation in physical therapy involves a physical exam and evaluation followed by treatment interventions including but not limited to manual therapies/bodywork, exercise prescription, neuromuscular re-education, functional retraining, and integrative education. Brightside is proud to offer services to all appropriate patients regardless of age, gender, ethnicity, sexuality, or disability. All treatments will be thoroughly explained to you prior to performing them, and all interventions are optional.

As with all forms of medical treatment, there are benefits and risks involved with physical therapy. Response to physical therapy intervention is unique to each individual and may even vary from day to day depending on your current condition. This means it is not possible to accurately predict your response to a specific intervention, and Brightside cannot make guarantees regarding your reactions or outcomes. Furthermore, there is a possibility that the physical therapy treatment may result in aggravation of existing symptoms and may cause pain or injury. **Participation in physical therapy is an agreement to consistently communicate your health conditions as well as any changes in your symptoms or health conditions with your therapist prior to and during treatment as needed.**

You are invited to decline any part of your treatment at any time before or during treatment if you feel physically or emotionally uncomfortable or unsafe. You are invited to ask questions about the risks, benefits, and rationale for any suggested treatments prior to or during the application of said treatment. Questioning or declining any particular treatment intervention will not affect your eligibility to continue receiving physical therapy without judgement or discrimination.

**I, _____, have read this consent form, understand the risks inherent in physical therapy, and hereby agree to release and hold harmless Brightside Integrative Physical Therapy from liability for any adverse effects I experience as a result of my participation in physical therapy. I agree to disclose any pre-existing health conditions that may impact my participation in physical therapy. I understand that I have the right to question, decline, or terminate services at any time. I agree that Brightside Integrative Physical Therapy is not responsible for any damages that result from my failure to adequately communicate my needs. I willingly and enthusiastically agree to participate in the prescribed plan of care to the best of my ability and at my own risk with the expectation of ongoing transparency.**

**Print name:** _____

**Date:** _____/_____/_____

**Signature:** _____

**Therapist:** _____

**Treatment Contract**

I, _____, have read and agree to the following:

I agree to attend my scheduled appointments. If I cannot, I agree to provide 48 hours notice prior to canceling or rescheduling whenever possible. I understand that canceling with less than 24 hours notice will result in a 50% cancellation fee.

The 90 minute evaluation investment is agreed upon to be $150 with followup sessions agreed upon to be $150 per 90 minutes. I understand this will be collected on the day of service unless otherwise stated.

_____

Privacy Practices

Brightside Integrative Physical Therapy values a transparent and mutually respectful alliance between the patient and the physical therapist. Brightside also values your privacy, and this office will protect the integrity and confidentiality of your information to the highest degree possible.

All your personal contact, payment, and medical information will be stored securely and used exclusively by this office unless otherwise requested by you, the patient, or subpoenaed by law. Your personal information and treatment details will NEVER be transmitted electronically, shared with an insurance entity, submitted to shared databases, disclosed on social media, or discussed with other providers without your express consent.

**I, _____ have read and agree to the terms of this arrangement.**

**Signature**_____ **Date** _____/_____/_____

**Direct Access Acknowledgment**

In the state of Tennessee, the law allows you to directly initiate physical therapy evaluation and receive treatment without the need for a physician's referral. This is called "Direct Access." The information you provide on this form will allow Brightside to provide your care in compliance with law with the least amount of administrative inconvenience and the maximum protection of your private information. This law requires Brightside to notify your physician that you are receiving physical therapy, but the details of your treatment will remain confidential.

Patient's name _____ Date _____/_____/_____

Primary Care Provider _____ Phone # _____
Have you ever been diagnosed with a chronic condition by a physician? Yes / No If so, please specify:

_____

*Please list any other specialists involved in your care:*

Name of Provider_____ Phone # _____
Speciality_____ Last seen ____/____/____ Followup Scheduled? Yes / No

Name of Provider_____ Phone # _____
Speciality_____ Last seen ____/____/____ Followup Scheduled? Yes / No

Name of Provider_____ Phone # _____
Speciality_____ Last seen ____/____/____ Followup Scheduled? Yes / No

Name of Provider_____ Phone # _____
Speciality_____ Last seen ____/____/____ Followup Scheduled? Yes / No

**I would like Brightside Integrative Physical Therapy to notify**
**[My PCP] / [All my specialists] / [none of the above] / [_____]**
**of my participation in physical therapy.**

**Signature**_____ **Date** _____/_____/_____

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**You:**

Your Name: _____

Pronouns:_____Date of Birth: _____/_____/_____ Age: _____

Phone: _____ Email: _____

Address: _____ Emergency Contact:_____

_____ Phone: _____

_____ Relationship: _____

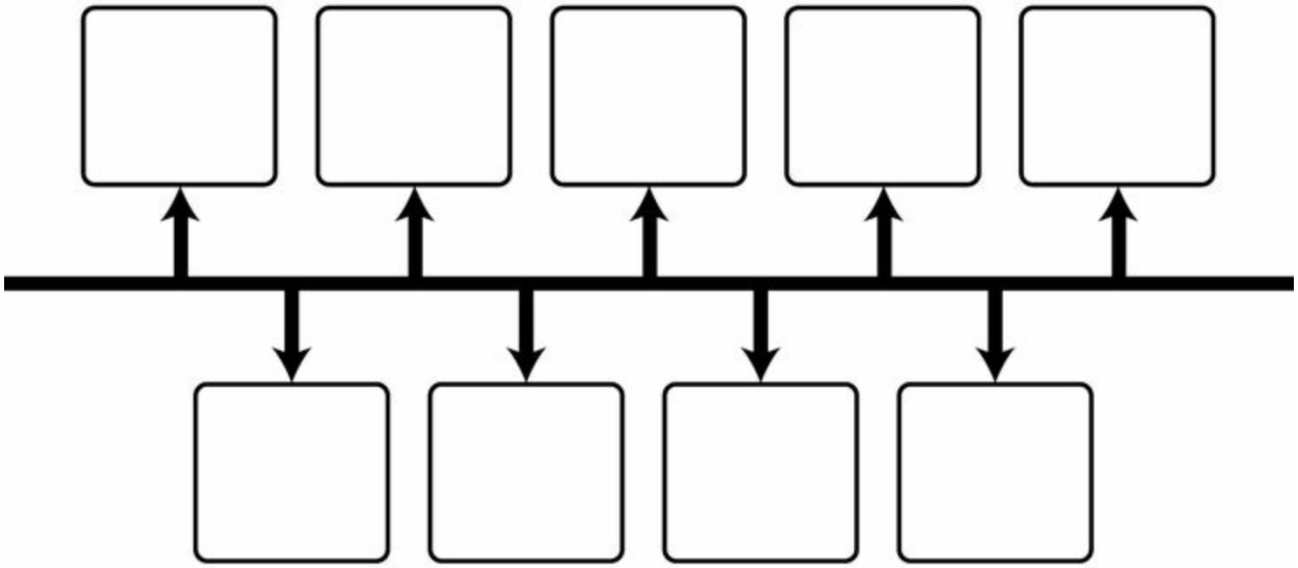
## Your Current Complaint:

Please describe the issue from which you are seeking relief:

_____

_____

*Use this diagram to create a timeline of your history with this issue. When did it start? What other treatments have you received? Try to include any major injuries, surgeries, and other stressful life events that may be related.*



What makes it feel better?

_____

What makes it feel worse?

_____

What treatments or tests have you already had?

_____

_____

What has helped the most?

_____

Did anything make it worse?

_____

**Your Goals:**

If this issue could go away, how would your life improve? _____

_____

_____

_____

*On the scale below, please indicate how much this issue interferes with your activities of daily life:*

|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
0 10 20 30 40 50 60 70 80 90 100

Think of some specific activities that this issue interferes with the most (Work, sleep, intimacy, hygiene, cleaning house, playing with kids, self-esteem, etc). What would you like to change? (If unsure, leave blank)

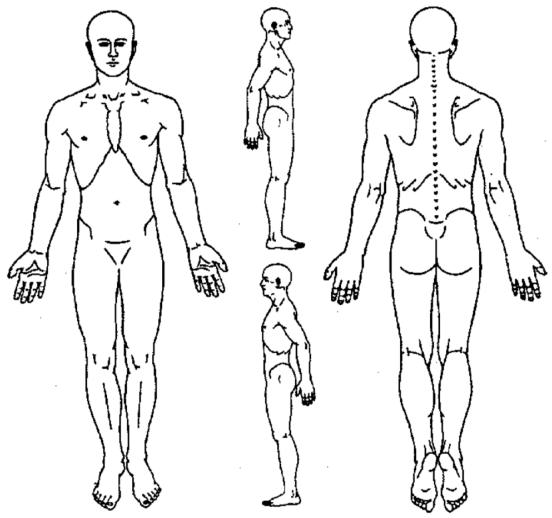
*ex. Will be able to walk more than 20 minutes without back pain, go to the gym without leaking, etc*

1._____

2._____

3._____

*On the diagram below, please illustrate where and how you feel your symptoms. Add as much detail as you need.*



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## Your History:

Medical History

Have you had any of the following? (Circle all that apply)

| | | |
|---|---|---|
| Anemia | Depression | Kidney problems |
| Anxiety | Diabetes | Liver problems |
| Asthma | Dizziness | Night pain |
| Arthritis | Fainting | Numbness/tingling |
| Autoimmune disorder | Hearing problems | Trauma |
| Cancer | Heart problems | Unexplained weight loss |
| Circulation problems | Incontinence | Vision problems |

Others:_____

_____

_____

Allergies:_____

Surgeries:_____

_____

Lifestyle History

Occupation: _____ Hours worked each week: _____

Do you find your job physically difficult or stressful? How so?_____

_____

How much water do you drink per day? _____ Other fluids? _____

Do you use tobacco? _____ What form? _____ How much/often?_____

Do you sleep well? _____ If no, why not?_____

What do you do for exercise? _____

Are you sexually active? _____ Monogamous / Other / _____ Have you ever had a "Sex Ed" class? _____

Other comments:_____

_____

Women's Health History:

Do you have a menstrual cycle? _____ Do you have pain/difficulty with it?_____

_____

Are you currently pregnant?_____ How far along? _____ Nursing?_____ For how long? _____

Previous pregnancies? _____ Complications? _____

_____

Do you prefer using tampons / disposable pads / reusable pads / menstrual cup / other _____

Do you get an annual physical?____ Pap smear?____ Mammogram? ____ Other?_____

Other comments: _____

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Pelvic Health Screen

*Please check all that apply*

- ◯ I sometimes have pelvic pain (in genitals, perineum, pubic or bladder area, or pain with urination) that exceeds a '3' on a 1-10 pain scale, with 10 being the worst pain imaginable
- ◯ I can remember falling onto my tailbone, lower back, or buttocks (even in childhood)
- ◯ I sometimes experience one or more of the following urinary symptoms
  - Accidental loss of urine
  - Feeling unable to completely empty my bladder
  - Having to void within a few minutes of a previous void
  - Pain or burning with urination
  - Difficulty starting or frequent stopping/starting of urine stream
- ◯ I often or occasionally have to get up to urinate two or more times at night
- ◯ I sometimes have a feeling of increased pelvic pressure or the sensation of my pelvic organs slipping down or falling out
- ◯ I have a history of pain in my low back, hip, groin, or tailbone or have had sciatica
- ◯ I sometimes experience one or more of the following bowel symptoms
  - Loss of bowel control
  - Feeling unable to completely empty my bowels
  - Straining or pain with a bowel movement
  - Difficulty initiating a bowel movement
- ◯ I sometimes experience pain or discomfort with sexual activity or intercourse
- ◯ Sexual activity increases one or more of my other symptoms
- ◯ Prolonged sitting increases my symptoms

Finally, what else would you like me to know about you?

_____

_____

_____

_____

_____

_____

**Medications Disclosure**

In order to offer you the best care, it is valuable for us to identify what substances are active in your system, prescribed or otherwise. The information you provide on this form will also help me better understand your health conditions and more accurately anticipate your response to therapeutic interventions.

**This information will be used exclusively by Brightside Integrative Physical Therapy.**

Medication name _____ Dosage/Frequency _____ Taken AM / PM
Side effects you experience_____

Medication name _____ Dosage/Frequency _____ Taken AM / PM
Side effects you experience_____

Medication name _____ Dosage/Frequency _____ Taken AM / PM
Side effects you experience_____

Medication name _____ Dosage/Frequency _____ Taken AM / PM
Side effects you experience_____

Medication name _____ Dosage/Frequency _____ Taken AM / PM
Side effects you experience_____

Medication name _____ Dosage/Frequency _____ Taken AM / PM
Side effects you experience_____

Other medications:_____
_____

Allergies:_____

Do you follow a specific diet? _____How long have you been on this diet? _____

Multivitamin? Yes / No Supplements? _____

Cigarettes? Packs per day_____ Alcohol? Drinks per day_____ Caffeine? Drinks per day_____

Cannabis? _____ Others? _____
_____

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THE END

You made it!