Wellness Center
Inside Outside®
Medical Spa

DXA Body Composition Client Questionnaire

Date: _____ **Client ID #_____**

Name: _____
Date of Birth: _____ Age: ____ Sex: M or F
Address: _____
City/State/Zip:_____
Cell Phone: _____ Other Phone: _____
Email (Confidential): _____

We are HIPPA Compliant and agree to secure your Protected Health Information (PHI) In accordance with applicable laws.

Do we have your permission to send you Your PHI and appointment reminders (ie Scans) Yes___ No ___ Via Email or Text Messages?
Would you like to receive our Newsletter (Only every 4 Months) YES / NO

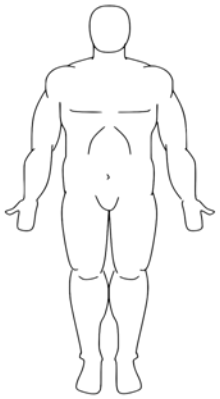
Present Employer: _____
How did you hear about us? _____

Other than body composition, what concerns about your health may we be able to help you with?

_____

_____

Circle the area(s) you are most concerned about regarding body composition:



Details (i.e. fat, muscle, etc.):

_____

_____

_____