Wellness Center Inside Outside® Medical Spa

DXA Bone Density Testing Client Intake Form

Date Forms Completed: 5/5/2023 **(Client Update}** **Client #(Office Use)** _____

Last Name:	**First Name:**	**M:** ☐	**F:** ☐
Date of Birth:	**Age:**		
Address:			
City:	**State:**	**Zip:**	
Your Home Phone:	**Your Cell Phone:**		
Your Doctors Name to send copy of Report:			
At your tallest, what was your height in feet and inches? ____ft ___in			
What has been your maximum weight (non-pregnant)? _____lbs Weight at about 20yrs? ____lbs			
If you are still menstruating, what was the date of your last period? ___month ___year			
If passed menopause, estimate the age you last had a menstrual period?			
How many children have you given birth to?			
Email:	**Would you like to receive our end of year newsletter? Y:☐ N: ☐**		
Present Employer:	**How did you hear about us?**		
Do you have any internal prostheses? No: ☐	**Hip/Knee ☐ Spine ☐ Other _____**		
Are you wearing a Continuous Glucose Monitor or Insulin Pump? No: ☐ Yes: ☐			

Have you had previous DXA Bone Density Scans? No: ☐ Yes: ☐ Date(s) Year: _____

Do You have copies of the scans or the Reports? No: ☐ Yes: ☐ Please bring with you if you do.

Please list all medications (prescription and over-the-counter), vitamins and mineral supplements, natural herbs or drugs, and homeopathic therapies you are currently taking.

Medication Name	Dose	Number taken daily

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DXA Bone Density Risk Factor Questionnaire #1

Last Name: _____ **First Name:** _____ **Date:** 5/5/2023 **Client#:** _____

Risk Factors We Can't Change (Unavoidable)

Please check the box by any condition that applies to you now or in the past.

Personal History-Other			
☐	I am Female	☐	I am of Northern European Ancestry
☐	I am Male	☐	I have a family history of osteoporosis
☐	I am Caucasian (white)	☐	I have lost a little height in the last 5-10 years
☐	I am African-American (black)	☐	I have weighed less than 127lbs most of my life
☐	I am Asian (oriental)	☐	I have thin and small bones
☐	I am Hispanic	☐	I am over 50 years old
Medical History-Other			
☐	I have history of a kidney stone	☐	I have had a spine compression fracture
☐	I have a history of an over-active thyroid	☐	I have had a wrist fracture
☐	I have a history of phlebitis	☐	I have had a hip fracture
☐	I have a history of pulmonary embolism	☐	I have had a rib fracture
☐	I have a history of a low thyroid gland	☐	I have had a pelvic fracture
☐	I have a history of a high blood calcium level	☐	I have had a stress fracture _____
☐	I have a history of hyperparathyroidism	☐	I have had a fracture not listed_____
☐	I've been told I have osteoporosis/osteopenia	☐	I have a history of kidney failure
☐	I have back pain	☐	I have a history of kidney transplant
☐	I have scoliosis	☐	I am on kidney dialysis
☐	I have a history of multiple myeloma	☐	I have a history of heart transplant
☐	I have a history of alcoholism	☐	I have a history of anorexia nervosa or bulimia
☐	I have rheumatoid arthritis	☐	I have a history of intestinal malabsorption
☐	I have Type 1 Diabetes	☐	I have had intestinal bypass surgery
☐	I have Type 2 Diabetes	☐	I have inflammatory bowel disease
☐	I have a history of Back Surgery	☐	I have a history of Hip Surgery R☐ or L☐
Female Reproductive System History-Other			
☐	I had a premature menopause before age 40	☐	I have a history of amenorrhea
☐	I have passed menopause	☐	I had a hysterectomy (surgical removal uterus)
☐	I lost my periods for a while at some time	☐	I have a history of cervical or uterine cancer
☐	My periods began after age 16	☐	I have fibrocystic breast disease
☐	I lost periods due to a heavy exercise routine	☐	I have a history of breast cancer
☐	I had both ovaries removed surgically	☐	I have a family history of breast cancer
☐	I have a history of irregular menstrual periods	☐	I have uterine fibroids

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DXA Bone Density Risk Factor Questionnaire #2

Last Name: _____ **First Name:** _____ **Date:** 5/5/2023 **Client#:** _____

Risk Factors We Can't Change (Unavoidable)

Please check the box by any condition that applies to you now or in the past.

Medication History Or Present Use			
☐	I have used cortisone-like drugs (prednisone)	☐	I have used thyroid hormone pills
☐	I have used phenobarbital/Dilantin for seizures	☐	I have a history treatment for cancer with chemotherapy (Methotrexate especially)
☐	I use Mylanta or Maalox (With Aluminum)	☐	I have used anti-rejection drugs for transplant
☐	I have used Lasix for high blood pressure	☐	I have used heparin to prevent blood clotting
☐	I have used Chloestyramine for cholesterol	☐	I have used Fosamax, Actonel or Prolia
☐	I have used Estrogen Pills after menopause	☐	I have used Testosterone
☐	I have used Growth Hormone	☐	I have used Statin drugs

Risk Factors We Can Change (Avoidable)

Please check the box by any condition that applies to you now or in the past.

Diet and Lifestyle History			
☐	I usually eat meat other than fish daily	☐	I take Omega 3 Supplements
☐	I usually eat fish 2 or 3 times a week	☐	I strength train 1 or more times weekly
☐	I follow a vegetarian diet	☐	I don't do strength training regularly
☐	I use 2 or more alcoholic drinks daily	☐	I use 2 or more soft drinks daily
☐	I regularly include dairy in my diet	☐	I use of 2 or more cups of coffee or tea daily
☐	I avoid milk and other dairy foods	☐	I have used Tobacco regularly in the past
☐	I have a lot of stress in my life	☐	I get less than 8 hours sleep usually

We are a HIPPA Covered Entity & manage your Protected Health Information (PHI) following applicable laws as indicted in our Notice of Privacy Policies which you have been given a link/chance to review.

Do we have your Authorization to send you your PHI (ie Scan Results) and appointment reminders Via Email and/or Text Messages? Yes☐ No☐ If Yes, You need to also sign the Authorization and Consent Form for these Channels of Communication and the Informed Consent form for the actual scan which are the next 2 pages of this document. Some of the fields on these pages are pre-populated.

Signature: _____ **Date:** 5/5/2023

Signature of Parent If Age less 18: _____ **Date:** 5/5/2023

Reviewed by Dr. Christian: Yes☐ No☐ Date: _____

Plan: ☐ **Proceed to DXA Bone Density Protocol**

☐ **Delay/Abort Testing (Reason):** _____

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Revised 3/11/2023

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Authorization & Informed Consent for Transmission of PHI & ePHI Via Possibly Unsecured Email, Internet, Text, Fax or Voice Communication Channels

Last Name: _____ **First Name:** _____ **(Office Use) Client #:** _____

I expressly request, authorize, direct, permit and unequivocally consent to Inside Outside Wellness Center & Medical Spa to transmit my Protected Health Information (PHI) & Electronic Protected Health Information (ePHI) to me via *possibly* unsecured text/fax/voice message/internet cloud links/email.

I understand that Inside Outside Wellness Center & Medical Spa does not have the capability to completely guarantee that all text/fax/voice messages and email/internet data are transmitted in an encrypted or secured format.

I understand, however, in accordance with HIPPA Regulations, that Intake Documents, Consent Forms, Treatment Records, DXA Scan Results, Lab Results and other Identifiable PHI or ePHI will be stored in secured physical locations and/or HIPPA compliant encrypted cloud sites such as Sync.com and Paubox.com. Therefore, PHI or ePHI can and will be sent to me, by virtue of this consent, by email/text via a HIPPA compliant encrypted link via Sync.com for download and personal use.

I expressly waive any claims or rights with respect to transmission of some ePHI or PHI via possibly unsecured text/voice messages/email/internet. This could include Scheduling of appointments, Confirmation of appointments, Rescheduling appointments, Appointment reminders, Directions to our location, and post visit "Thank You" purposes. These communications might also include the nature of my appointment ie Spa Procedure, Botox Treatment and ALLE Reward Information, DXA Scan or Hi-Lo Strength Training, clarification of the appointment details, additional information about the service I received or reminders or instructions for post procedure care.

I fully understand that third parties may attempt to or actually access, use and disclose some PHI or ePHI stored and transmitted by HIPPA Compliant entities such as Inside Outside Wellness Center & Medical Spa and Sync.com and Paubox.com to my mobile phone or desktop computer via text/voice message or email/internet. Once I receive PHI or ePHI, Inside Outside has no responsibility for it's security.

I fully understand the risks of transmitting text/fax/voice messages or email/internet containing PHI or ePHI and I am willing to accept those risks.

I knowingly, intentionally and voluntarily waive all rights, claims and damages relating to the negligence, breach of confidentiality or other tort and all other legal claims that could be asserted against Inside Outside Wellness Center & Medical Spa any of its employees, agents, members or otherwise as a result of any third person improperly accessing, using or disclosing my PHI or ePHI as a result of transmission via unsecured text/fax/voice messaging, Internet or email.

Phone/Text Number: _____ **Email:** _____

Signature: _____ **Date:** 5/5/2023

Form CL100 Auth Revised 10/17/2022

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Informed Consent for DXA Body/Bone Scan Testing

Last Name: _____ **First Name:** _____ **Client # (Office Use):** _____

This form contains information about your request to have a DXA Bone and Body Composition Test performed by Dr. Charles B. Christian, Jr. dba Inside Outside Wellness Center & Medical Spa.

The goal is to give you detailed information about your Bone Density , Body Composition , Fat Mass , Lean Mass and Body Fat Distribution, including an estimate of your Visceral Fat. This information can be used to help create a Nutrition Prescription and determine what your risk of fracture related to Low Bone Density might be and if you need a FDA approved drug to improve bone density.

There is a small amount of radiation involved but it is so small none of the operators or you will need any extra protection and the room does not have to be shielded. The amount of radiation is about the same as you would receive in a few hours from the background radiation from the Sun and Radon in the Ground. There are no known risks or discomforts for the approximately 30 minutes for the Scans.

For Women Only:

I hereby state that I have been instructed by the staff of Inside Outside Wellness Center & Medical Spa that DXA Scan is an elective procedure and that I *MUST NOT* have a DXA Scan performed if I am pregnant, or have any suspicion that I may be pregnant. I have advised the staff of Inside Outside Wellness Center & Medical Spa that I am not pregnant, do not have any suspicion I may be pregnant, and I have elected to have this procedure performed today.

Should it be determined at a later date that I am pregnant at the time the scan was performed, I agree to hold Inside Outside Wellness Center & Medical Spa, and any partners/affiliates of Inside Outside Wellness Center & Medical Spa, harmless from any liability and any potential future damages.
Initials _____

I understand that I need to remove a Continuous Glucose Monitor (CGM) and a external Insulin Pump prior to the scan otherwise the scan should not be performed.

I understand that my participation is purely voluntary and my permission to perform this testing is freely given. I understand the risks and expected benefits. Inside Outside cannot be held responsible for any mental or physical discomfort as a result of the test.

The data from the scan is considered Protected Health Information and will be stored in a HIPPA approved encrypted hard drive at Inside Outside and encrypted at Sync.com for backup. The digital copy of the scan will be sent to me via an encrypted link by Dr. Christian or be available for download on the FitnesCity Dashboard for FitnesCity Clients.

This informed consent form applies to all future followup scans. Women will be required to sign another Pregnancy Disclaimer for Followup Scans.

Signature: _____ **Date:** 5/5/2023

Signature of Parent If Age less 18: _____ **Date:** _____

Form DXA Consent Revised 9/22/22

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Wellness Center Inside Outside® Medical Spa

Office Use
Client Education Documentation

Last Name _____ **First Name** _____ **Date** 5/5/2023 **Client #** _____

Topic: ☐ Botox ☐ DXA Body Composition ☐ Nutrition Prescription ☐ DXA Bone Density
☐ Skin Care Products ☐ Nutrition Supplements/Testing ☐ Chemical Peel
☐ Rejuvapen Procedure **Other** _____

Reason for Education: ☐ Give enough information so client understands procedure being requested, cost of procedure, risks and benefits, set expectations for procedure and review post procedure and followup instructions. ☐ Other _____

Educational Tools

Power Point Presentation: ☐ DXA Body Composition ☐ DXA Bone Density
☐ Nutrition Prescription & Implementation ☐ Botox-Dynamic Wrinkles ☐ Botox-Bruxism
☐ Chemical Peel ☐ Skin Care ☐ Microdermabrasion ☐ Rejuvapen

☐ Drawing : ☐ Botox ☐ Drawing Other _____
☐ Extensive Dialogue: Omega 3 Testing
☐ Extensive Dialogue: _____
☐ Handout : ☐ Post Procedure ☐ Brochure ☐ Other _____

Comments

_____

_____

Who received this education?
☐ Client ☐ Parent/Guardian ☐ Other _____

Was adequate understanding achieved?
Yes ☐ No ☐

Client Initials: _____ **Date** 5/5/2023

Clinical Staff Initials: _____ **Date** 5/5/2023

Form DR100 Education Revised 10/6/2022

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Initial DXA Bone Density Scan
Client Medical Record
Based on Intake Form Data

Last Name: _____ **First Name:** _____ **Date:** 5/5/2023 **Client #**_____

Chief Complaint: ___Y/O M☐ F☐ desires Baseline/Follow-up DXA Bone Density Scan.

History and Risk Factors: See the Intake Form for Details

Internal Metal/Prosthesis which might interfere with scan results No☐ Yes☐

☐Hip/Knee ☐Spine ☐Breast ☐Other: _____

Pregnancy Status: Pregnant: No☐ Yes☐ Not Sure☐ See DXA Consent Form

Continuous Glucose Monitor? No☐ Yes☐ Removed prior to scan Yes☐ No☐

Insulin Pump? No☐ Yes☐ Removed prior to scan Yes☐ No☐

Any Contraindication for Scan: No☐ Yes☐ Describe _____

Consent Form signed: Yes☐ No☐ Signature & Consent of Parent If Age less 18: N/A☐ Yes☐ No☐

Signed up for Newsletter? Yes☐ No☐ Authorization for Email/Text/Voice Yes☐ No☐

Indication for scan: See Intake Form for Details

☐Baseline ☐Multiple Risk Factors ☐Followup ☐Other _____

Notes: _____

Desires copy of scan and report to be sent to Care Provider? Yes☐ No☐

Name of Provider: _____

Plan: ☐DXA Bone Density Testing Protocol

Assisted by Initials: _____

Dr. Christian Signature: _____ **Date:** 5/5/2023

Form DXABone DR101 Revised 3/11/2023

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