"THE ULTIMATE WELLNESS GROUP"

"Your Medicine Cabinet is in Your Kitchen"

Dr. Akili Muhammad, M.D.
Family Medicine & Natural Health
Phone: 832-429-4576
Fax: 832-201-7011
Email: theultimatewellnessgroup@gmail.com

NUTRITIONAL PROGRAM QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your record.

You can complete this form on-line and save to your computer. **PLEASE** email the completed form to **appointments@theultimatewellnessgroup.com** or fax the completed form to 832-201-7011 **48 hours prior to your scheduled appointment.**

Name: *(Last, First, M.I.)*		**Gender:**	☐ M ☐ F	**DOB:**		**Age:**	
Prefer to be called		**Marital status:**			**No. of Children:**		
Occupation:		**Spouse:**					
Address:		**City:**		**State:**		**Zip Code:**	
Primary Phone Number:		**Email:**					

FITNESS HISTORY

What do you drink daily?
How often do you exercise:
What type of exercise?
Type of daily work:

PRIMARY COMPLIANTS

List of dietary or health complaints you are seeking to address using a natural health approach

List any medical problems that other doctors have diagnosed

Surgeries		
Year	Reason	Outcome

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List your prescribed drugs, over-the-counter drugs, such as vitamins, food supplements and inhalers		
Name the Drug	Strength	Frequency Taken

HEALTH HABITS

Exercise	☐ Sedentary (No exercise)			
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)			
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)			
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)			
	When were you in the best shape of your life?			
	When did you first start thinking about getting in shape?			
	On a scale of 1-10, how would you rate your present health and fitness level (1=Worst 10=Best)?			
	Have you been exercising consistently for the past 3 months?	☐ Yes	☐ No	
Weight	Are you dieting?	☐ Yes	☐ No	
	Number of meals you eat in an average day?			
	Rank salt intake	☐ Hi	☐ Med	☐ Low
	Is anyone in your immediate family overweight?			
	Were you overweight as a child?	☐ Yes	☐ No	

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Nutrition	On a scale of 1-10, how would you rate your nutritional state of health (1=very poor 10=excellent)?			
	How many times a day do you usually eat (including snacks)?			
	Do you skip meals?	☐ Yes	☐ No	☐ Sometimes
	Do you eat breakfast?	☐ Yes	☐ No	☐ Sometimes
	Do you eat late at night?	☐ Yes	☐ No	☐ Sometimes
	What activities do you engage in while eating?			
	How many glasses of water do you consume daily?			
	What type of water do you normally drink?			
	Do you feel drops in your energy levels throughout the day?	☐ Yes	☐ No	When:
	At work, do you usually?	☐ Eat out	☐ Bring my food	☐ Other:
	How many times per week do you eat out?			
	Do you do your own shopping?	☐ Yes	☐ No	
	Do you do your own cooking	☐ Yes	☐ No	
	Besides hunger, what other reason(s) do you eat?	☐ Boredom ☐ Social ☐ Stressed ☐ Tired ☐ Depressed ☐ Happy ☐ Nervous		
	Do you eat passed the point of hunger?	☐ Often	☐ Sometimes	☐ Never
	Do you eat foods high in fat and sugar?	☐ Often	☐ Sometimes	☐ Never
Caffeine	☐ None ☐ Coffee ☐ Tea ☐ Cola Other			
	Number of cups/cans per day?			
Alcohol	Do you drink alcohol?	☐ Yes	☐ No	
	How many drinks per week?			
Tobacco	Do you use tobacco? ☐ Yes ☐ No			
	☐ Cigarettes – pks./day ☐ Chew - #/day ☐ Pipe - #/day ☐ Cigars - #/day			
	☐ # of years ☐ Or year quit			
Drugs	Do you currently use recreational or street drugs?	☐ Yes	☐ No	
Rest and Relaxation	How many hours do you regularly sleep at night?			
	On a scale of 1 – 10, how would you rate your stress (1=very low 10=very high)?			
	Does your job require travel?	☐ Yes	☐ No	
	List your three biggest stressors:			

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List three areas of your nutrition you would like to change.

What stops you from making the progress you desire

FITNESS PROGRAM

What are you willing to do to improve your health?

What have you accomplished as of today?

What are your expectations from your specialized program

COMMITTMENT

How committed are you to achieving your fitness goals	☐ Very	☐ Semi	☐ Not Very

What do you think the most important thing we can do to help you achieve your health and fitness goals?

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Outline what you feel are the obstacles or your potential actions, behaviors or activities that could impede your progress towards accomplishing your goals (i.e. not training consistently, upcoming vacation, busy season at work, not following the program, allowing other responsibilities to become a priority over exercise etc.)
Outline 3 methods that you plan to use to overcome these obstacles

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every_____days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Date of last pap and rectal exam? Any concerns?		

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MEN ONLY

Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam?	☐ Yes	☐ No

OTHER PROBLEMS

Check if you have, or have had any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

Customer satisfaction is the best advertisement. Who may we thank for your referral?

Name:

Email address:

Phone No.

Most people will require anywhere between four and twelve sessions in order to fully integrate changes that lead to healthful results.

Health is a Lifetime Commitment.

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