

Introduction to Health-N- Wellness Services

Congratulations on requesting information on our Wellness services. You may currently have a health condition and are seeking additional support in regaining your health. You may be a rare person who currently is doing well and looking to become proactive in staying well and preventing the slow decline of health that so many suffer from. You may have concerns because parents or siblings suffer from diseases you are trying to avoid and you want to lower your risk. For whatever the reason, my office is here to support you, 100%. Our commitment will match your commitment. Your willingness to learn will drive our desire to teach. Your willingness to change will meet with our enthusiastic support. Your desire to engage in improving your lifestyle choices will drive our commitment to help you obtain your health goals.

YOUR COMMITMENT:

Your health is dependent upon you and the decisions you make every day. No doctor can give you health. You must be committed to following the recommendations provided and being dedicated to making the necessary lifestyle changes that are going to result in health. Whatever health challenges you face today are the results of making decisions that did not support your health. Our job is to help you become better educated so you can make better choices and as a result, experience improved health. The key to success is **YOU**.

HEALTH CARE VERSUS DISEASE MANAGEMENT:

Your current health insurance serves only one purpose and it has absolutely nothing to do with Health. The purpose of your health care insurance is to pay for the treatment of disease. The purpose of this wellness program is to restore health and prevent disease. What that means to you is that your health insurance will not pay for any part of this program. There are no exceptions to this: no current health care policy pays for wellness care.

For example: If you drive a car and you have collision and comprehensive coverage on that car, the way that insurance works is a good example of how this program works and how your current health care insurance policy views this type program. Your automobile insurance does not pay you to get engine repairs, change your oil, rotate tires or to perform any preventive maintenance or repairs. Your automobile insurance only pays to have repairs done once you have crashed the car. That's how our current health insurance system works. Since this wellness program does not have as its purpose to treat disease but does have as its purpose to restore normal health and function by supporting the return of healthy physiology and metabolism, your current health insurance will not pay for any part or portion of your Health-n-Wellness program.

This makes all fees for services and any product your personal financial responsibility.

OUR PURPOSE:

The purpose of my office is not to see how many people we can save through the intervention of drugs and surgery. Our purpose is to help people regain and restore their health through the correction of the underlying cause. Our purpose is to educate and support health to be restored and disease and disability prevented. We are dedicated to providing health care and not supporting disease management.

HEALTH 'N WELLNESS SOLUTIONS

Dennis Mutell, D.C.

832 E. Boston Street #8 Covington, LA 70433 985-871-9300

Name: _____ Birth date: _____ Age: _____ SS #: _____

Phone: _____ Cell Phone: _____ Email address: _____

Address: _____ City: _____ State: _____ Zip: _____

Male Female

Marital Status: M W S D

of children: _____

Occupation: _____ Employer: _____ Phone: _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

Spouse's Name: _____ Occupation: _____ Employer: _____

How did you learn about our office? _____

What are your current health concerns?: _____

Please list all current medications that you are taking: _____

Please list all nutritional supplements, vitamins or herbs you take: _____

Please list all the times you were in the hospital: _____

Please list all surgical procedures even if you don't feel it is relevant to your current concerns: _____

Please list all past medications you were on for any period over 1 month: _____

List all allergies to medications, foods or environment: _____

Have you ever seen a medical specialist for any condition? _____ Yes _____ No

If so, specialists name and reason for visit _____

Name of your current primary care doctor _____

Metabolic Assessment Form

Name: _____

Date: _____

**Please circle the appropriate number “0 – 3” on all questions below.
0 as the least / never to 3 as the most / always**

Category I

Feeling that bowels do not empty completely 0 1 2 3
 Lower abdominal pain relieved by passing stool or gas 0 1 2 3
 Alternating constipation and diarrhea 0 1 2 3
 Diarrhea 0 1 2 3
 Constipation 0 1 2 3
 Hard, dry or small stool 0 1 2 3
 Coated tongue or “fuzzy” debris on tongue 0 1 2 3
 Pass large amount of foul smelling gas 0 1 2 3
 More than 3 bowel movements daily 0 1 2 3
 Use laxatives frequently 0 1 2 3
 Total: _____

Category II

Excessive belching, burping, or bloating 0 1 2 3
 Gas immediately following a meal 0 1 2 3
 Offensive breath 0 1 2 3
 Difficult bowel movements 0 1 2 3
 Sense of fullness during and after meals 0 1 2 3
 Difficulty digesting fruits and vegetables: undigested foods found in stool 0 1 2 3
 Total: _____

Category III

Stomach pain, burning or aching 1 – 4 hours after eating 0 1 2 3
 Do you frequently use anti-acids? 0 1 2 3
 Feeling hungry and hour or two after eating 0 1 2 3
 Heartburn when lying down or bending forward 0 1 2 3
 Temporary relief from anti-acids, food, milk carbonated beverages. 0 1 2 3
 Digestive problem subside with rest and relaxation 0 1 2 3
 Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine 0 1 2 3
 Total: _____

Category IV

Roughage and fiber cause constipation 0 1 2 3
 Indigestion and fullness lasts 2 – 4 hours after eating 0 1 2 3
 Pain, tenderness, soreness on left side under rib cage 0 1 2 3
 Excessive passage of gas 0 1 2 3
 Nausea and/or vomiting 0 1 2 3

Stool undigested, foul smelling 0 1 2 3
 Mucous-like, greasy or poorly formed 0 1 2 3
 Frequent urination 0 1 2 3
 Increased thirst and appetite 0 1 2 3
 Difficulty losing weight 0 1 2 3
 Total: _____

Category V

Greasy or high fat foods cause distress 0 1 2 3
 Lower bowel gas and or bloating several hours after eating 0 1 2 3
 Bitter metallic taste in mouth especially in the morning 0 1 2 3
 Unexplained itchy skin 0 1 2 3
 Yellowish cast to eyes 0 1 2 3
 Stool color alternates from clay colored to normal brown 0 1 2 3
 Reddened skin, especially palms 0 1 2 3
 Dry or flaky skin and / or hair 0 1 2 3
 History of gallbladder attacks or stones 0 1 2 3
 Have you had your gallbladder removed Yes No
 Total: _____

Category VI

Crave sweets during the day 0 1 2 3
 Irritable if meals are missed 0 1 2 3
 Depend on coffee to keep yourself going or started 0 1 2 3
 Get lightheaded if meals are missed 0 1 2 3
 Eating relieves fatigue 0 1 2 3
 Feel shaky, jittery, tremors 0 1 2 3
 Agitated, easily upset or nervous 0 1 2 3
 Poor memory, forgetful 0 1 2 3
 Blurred vision 0 1 2 3
 Total: _____

Category VII

Fatigue after meals 0 1 2 3
 Crave sweets during the day 0 1 2 3
 Eating sweets does not relieve cravings for sugar 0 1 2 3
 Must have sweets after meals 0 1 2 3
 Waist girth is equal or larger than hip girth 0 1 2 3
 Frequent urination 0 1 2 3
 Increased thirst & appetite 0 1 2 3
 Difficulty losing weight 0 1 2 3
 Total: _____

Category VIII

Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Afternoon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3
Total:	_____			

Category IX

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under high amounts of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3
Total:	_____			

Category X

Tired, sluggish	0	1	2	3
Feel cold – hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight gain even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression, lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face or genitals or excessive falling hair	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3
Total:	_____			

Category XI

Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3
Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3
Total:	_____			

Category XII

Diminished sex drive	0	1	2	3
Menstrual disorders or lack of menstruation	0	1	2	3
Increased ability to eat sugars without symptoms	0	1	2	3
Total:	_____			

Category XIII

Increased sex drive	0	1	2	3
Tolerance to sugars reduced	0	1	2	3
“Splitting” type headaches	0	1	2	3
Total:	_____			

Category XIV (MALE ONLY)

Urination difficulty or dribbling	0	1	2	3
Urination frequent	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel evacuation	0	1	2	3
Leg nervousness at night	0	1	2	3
Total:	_____			

Category XV (MALE ONLY)

Decrease in libido	0	1	2	3
Decrease in spontaneous morning erections	0	1	2	3
Decrease in fullness of erections	0	1	2	3
Difficulty in maintaining morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decrease in physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3
Total:	_____			

Category XVI (FEMALE ONLY)

Are you perimenopausal	Yes	No		
Alternating menstrual cycle lengths	Yes	No		
Extended menstrual cycle, greater than 32 days	Yes	No		
Shortened menses, less than every 24 days	Yes	No		
Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne break outs	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss / thinning	0	1	2	3
Total:	_____			

Category XVII (FEMALE ONLY)

How many years have you been menopausal?	_____			
Since menopause, do you ever have uterine bleeding?	Yes	No		
Hot flashes	0	1	2	3
Mental foginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness or itching	0	1	2	3
Total:	_____			