NSP CLIENT ASSESSMENT FORM

NAME: _____ AGE: _____ DATE: _____

COMPLETE LEFT SIDE OF FORM ONLY: If any of the following symptoms or activities have occurred *within the past three months* (unless otherwise specified), please indicate by checking: **1** for mild or rarely occurring, **2** for moderate or regularly occurring, **3** for severe of often occurring, or **leave blank** if the symptom/statement does not apply.

Please complete this section			1	2	3	4	5	6	7	8	9	10
1	General fatigue or weakness		0	0		0	0	0	0			0
2	Difficulty losing weight		0				0		0			0
3	Frequent infections			0	0			0			0	
4	High stress lifestyle		0		0	0	0		0			
5	Smokes cigarettes				0	0	0	0	0			0
6	Drinking more than 12oz of coffee per day		0			0	0		0		0	0
7	Bad breath and/or body odour		0	0								
8	Constipated		0	0					0			
9	Puffy eyelids/dark circles under eyes		0	0	0			0	0		0	
10	Crave sugars, bread, alcohol			0	0	0	0		0	0		
11	Certain foods create digestive pain/cramping		0	0	0							
12	Have used antibiotics in past 10 years			0	0			0		0	0	
13	Diagnosed food allergies/sensitivities		0	0	0			0				
14	Poor concentration or memory			0	0	0	0		0			
15	Excessive gas after meals		0	0	0							
16	Skin irritations - breakouts/rashes		0	0	0				0	0		
17	High intake of processed animal protein		0	0	0		0				0	0
18	Regular intake of cow dairy products		0				0	0		0		0
19	Heavy alcohol consumption		0			0			0			0
20	Exposure to toxins/chemicals			0	0	0		0	0	0		
21	Frequent mood swings			0		0			0	0		
22	Depressed and/or irritable			0		0			0	0		
23	Frequent urinary tract infections			0	0						0	
24	Dry, brittle hair, split ends		0						0			
25	High consumption of saturated fats		0				0			0		
26	Nervousness/anxious/tension/worry		0	0		0	0		0			
27	Insomnia or lack of sleep/restless sleep				0	0	0		0			
28	Low amount of fibre in the diet		0	0			0					
29	Muscle cramps					0						0
30	Sleepy when sitting up						0		0			
31	Female: Menstrual cramps								0	0		
32	Bronchitis/asthma/pneumonia/emphysema			0	0			0				
33	Cellulite			0	0				0	0		
34	Cold hands and feet						0		0			
35	Varicose veins		0				0		0	0		
36	Feeling out of control/anger					0			0			
37	Environmental/chemical sensitivities		0	0	0	0		0				
38	Frequent yeast/fungus infections			0	0					0	0	
39	Bones break easily/porous bones		0									0
40	Exercise less than one/two times per week					0	0	0	0			0
SUBTOTALS:			0	0	0	0	0	0	0	0	0	0

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(**Enter: 1** for mild or rarely occurring, **2** for moderate or regularly occurring, **3** for severe or often occurring, or **leave blank** if the symptom/statement does not apply.)

Please complete this section			1	2	3	4	5	6	7	8	9	10
SUBTOTALS:			0	0	0	0	0	0	0	0	0	0
41	Excessive mucous build-up			0	0			0				
42	Easily winded or shortness of breath						0	0				
43	Pins and needles sensation					0	0					
44	Chest pains		0				0	0				
45	Very rapid or slow heart beat					0	0		0			
46	Painful, hard or thin bowel movements			0								
47	Alternating constipation/diarrhea			0								
48	Carrying abdominal/visceral weight		0		0		0		0			
49	Menopause symptoms/hot flashes								0	0		0
50	Female: PMS			0		0			0	0		
51	Difficulty urinating/voiding									0	0	
52	Swollen lymph glands, puffy throat			0	0			0				
53	Lower abdominal pain		0	0						0		
54	Frequent need to urinate								0		0	
55	Joint pain/swelling/stiffness			0	0						0	0
56	Sinus inflammation/discharge			0	0			0				
57	Cravings for salty foods						0		0		0	
58	Sudden weight gain/loss		0	0					0	0		
59	Headaches/migraines			0		0	0		0	0		0
60	Female: Taking birth control pills			0		0				0		
61	Lower back pains		0								0	0
62	Dry, flaky, rough skin		0						0			
63	Drink less than 6 glasses of water per day			0			0				0	
64	Water retention/edema				0		0				0	
65	Low or loss of libido			0		0			0	0		
66	Feeling heavy/bloated after meals		0	0								
67	Chronic cough or wheezing			0	0			0				
TOTALS:			0	0	0	0	0	0	0	0	0	0

SYSTEMS RATING TABLE:

1.	**Digestive**	**0**
2.	**Intestinal**	**0**
3.	**Immune/Lymphatic**	**0**
4.	**Nervous**	**0**
5.	**Circulatory/Cardiovascular**	**0**
6.	**Respiratory**	**0**
7.	**Glandular/Endocrine**	**0**
8.	**Reproductive**	**0**
9.	**Urinary**	**0**
10.	**Musculoskeletal**	**0**

COMMENTS: