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

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NAME: _____ AGE: _____ DATE: _____

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

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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: