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 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
1	General fatigue or weakness												
2	Difficulty losing weight												
3	Frequent illness/infections												
4	High stress Lifestyle												
5	Smoking												
6	Drinking more than 2 cups of coffee/day												
7	Bad breath and/or body odour												
8	Constipation												
9	Bags under eyes												
10	Crave sugars, bread, alcohol												
11	Difficulty digesting certain foods												
12	Have used antibiotics in past 10 years												
13	Allergies												
14	Poor concentration or memory												
15	Belching or burping after meals												
16	Skin/complexion problems												
17	Frequent consumption of red meat												
18	Regular use of dairy products												
19	Heavy alcohol consumption												
20	Exposure to toxins/chemicals												
21	Frequent mood swings												
22	Depressed and/or irritable												
23	Brittle fingernails												
24	Dry, brittle hair, split ends												
25	High fat/high cholesterol diet												
26	Nervousness/anxiety/tension/worry												
27	Insomnia/restless sleep												
28	Low fibre 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												
37	Food/chemical sensitivities												
38	Frequent yeast/fungus problems												
39	Bones break easily, osteoporosis												
40	Too little exercise												
	SCORES SUBTOTAL												

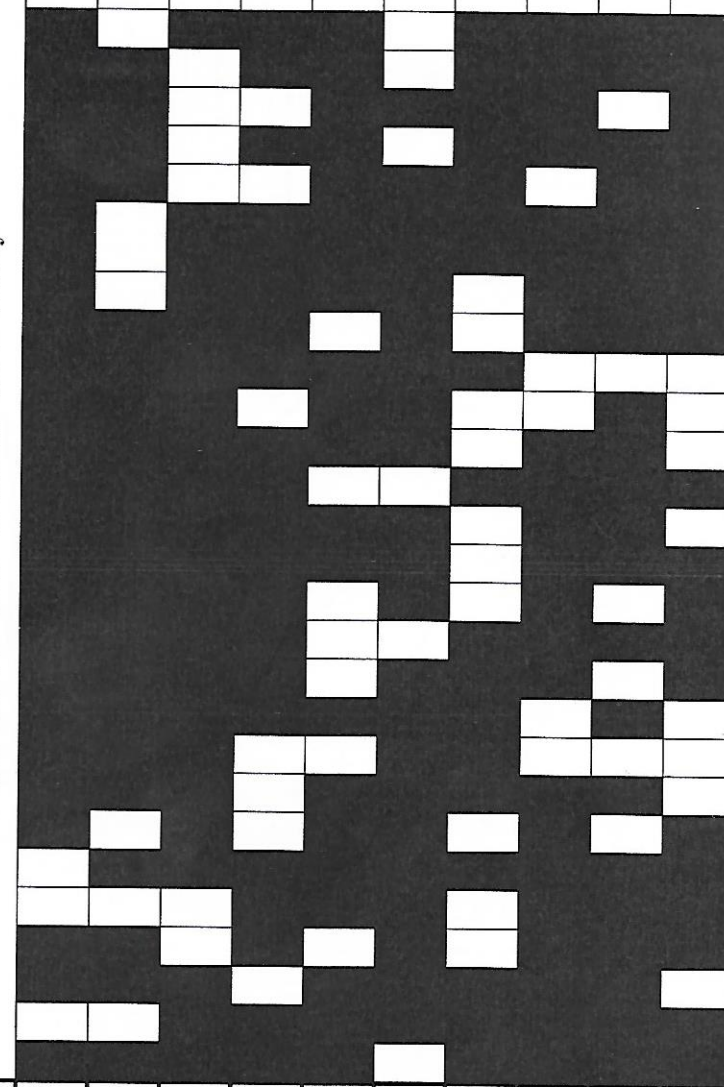
Right Side for Office Use Only

NAME: _____ DATE: _____ ASSESSMENT# _____

(Check: 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											
41	Excessive mucous											
42	Short of breath climbing stairs											
43	Tingling in lips, fingers, arms, legs											
44	Chest pains											
45	Very rapid or slow heart beat											
46	Painful, hard or thin bowel movements											
47	Alternating constipation/diarrhea											
48	Recurrent bladder infections											
49	Female: Menopause, hot flashes											
50	Female: PMS											
51	Difficult urination											
52	Swollen glands, puffy throat											
53	Lower abdominal pain											
54	Frequent need to urinate											
55	Joint pain											
56	Sinus inflammation/discharge											
57	Arthritis											
58	Sudden weight gain/loss											
59	Headaches/Migraines											
60	Female: Taking birth control pills											
61	Lower back pains											
62	Dry, flaky skin											
63	Drink less than 6 glasses of fluids/day											
64	Water retention											
65	Low sex drive											
66	Feeling heavy/bloated after meals											
67	Chronic cough											
SCORES SUBTOTAL												

Right Side for Office Use Only



SYSTEMS RATING TABLE: For Office Use Only

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

COMMENTS: