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 severely occurring, or **leave blank** if the symptom does not apply. Record your scores in the bolded column below.

▼

			1-10 for office use only									
	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/infection		■		■	■				■		■
4	High stress lifestyle			■					■		■	■
5	Smoking		■	■					■			
6	Drinking more than 2 cups of coffee						■					
7	Bad breath and/or body odor		■		■	■	■			■	■	■
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/memory		■				■	■	■	■		■
15	Belching or burping after meals			■	■	■	■	■	■	■	■	■
16	Skin/complexion problems				■	■		■			■	
17	Frequent consumption of red meats		■	■		■	■	■		■		■
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 fiber diet		■			■	■	■	■	■	■	■
29	Muscle cramps		■	■	■		■	■	■	■		■
30	Sleepy when sitting up		■	■		■	■	■	■	■	■	■
31	Female: menstrual cramps		■	■	■	■	■	■	■	■	■	
32	Bronchitis/asthma/pneumonia		■	■	■	■	■		■	■	■	■
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		■	■					■			■

			1-10 for office use only									
	Please complete this section		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
41	Excessive mucous											
42	Short of breath climbing stairs											
43	Tingling in lips, fingers, arms, legs											
44	Chest pain											
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											
64	Water retention											
65	Low sex drive											
66	Feeling heavy/bloated after meals											
67	Chronic cough											
	SCORE TOTAL											

SYSTEM 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: