

## 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.

<i>Please complete this section</i>		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										
	<b>SCORES SUBTOTAL</b>										

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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.)

<i>Please complete this section</i>		1	2	3	4	5	6	7	8	9	10
	<b>SUBTOTALS</b>										
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										
<b>SCORES TOTAL</b>											

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**SYSTEMS RATING TABLE:** For Office Use Only

**COMMENTS:**

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

# LIFESTYLE ASSESSMENT FORM

Name: \_\_\_\_\_

Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

*Please answer each of the following questions. Please use the back of the page for additional space.*

What is your purpose in coming here today? \_\_\_\_\_

What are your main health concerns/complaints? \_\_\_\_\_  
\_\_\_\_\_

Have you ever been diagnosed with an ailment related to your main health concern(s)? \_\_\_\_\_

Any trauma or loss in the last 5 years? \_\_\_\_\_

What level of stress do you feel you are experiencing at this time?

Minimal      Average      Considerable      Unbearable

What are the major causes or factors of your stress? (check all that apply)

financial      career      personal      marriage      health

family      spiritual      unfulfilled expectations

other (please elaborate) \_\_\_\_\_

How does your stress manifest itself? \_\_\_\_\_  
\_\_\_\_\_

Do you use any coping mechanisms? \_\_\_\_\_

What do you do for exercise? (indicate type, frequency and time) \_\_\_\_\_  
\_\_\_\_\_

How many hours on average do you sleep daily? (include naps) \_\_\_\_\_

What time do you go to sleep? \_\_\_\_\_ Awaken? \_\_\_\_\_

Do you awaken feeling rested?    Yes      No

What is your occupation? \_\_\_\_\_

Do you enjoy your work?    Yes      No      Sometimes

How many hours each day do you work? \_\_\_\_\_

At what times do you start and end work? \_\_\_\_\_

Do you smoke?    Yes      No      If yes, how much and for how long?

If no, does anyone in your household or workplace smoke?    Yes      No

Do you wish to gain weight?      lose weight?      how much? \_\_\_\_\_

How many hours do you spend daily, on average:

Driving \_\_\_\_\_ watching television \_\_\_\_\_ reading \_\_\_\_\_ in front of computer \_\_\_\_\_

What are your interests and hobbies? \_\_\_\_\_  
\_\_\_\_\_

Do you vacation regularly?    Yes      No

When was your last vacation? \_\_\_\_\_

Do you actively participate in any spiritual discipline (church, religious group, meditation, etc.)    Yes      No

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## LIFESTYLE ASSESSMENT FORM

Name: \_\_\_\_\_

### MEDICAL HISTORY:

Are you currently taking any medication?    Yes        No

List Reason(s) \_\_\_\_\_

Please list any vitamins, minerals, herbal or homeopathic remedies you are currently taking and the amounts/dosages: \_\_\_\_\_

\_\_\_\_\_

Do you have any allergies or sensitivities? If so, please list: \_\_\_\_\_

Do you have any silver-mercury fillings?    Yes        No

Have you ever been:

Diagnosed with an illness? Explain \_\_\_\_\_

\_\_\_\_\_

Hospitalized? Reason \_\_\_\_\_

How often do you have a bowel movement? \_\_\_\_\_

Do you strain to have a bowel movement?    Yes        No        Occasionally

Related to particular food or circumstances? \_\_\_\_\_

Do you have loose bowel movements?        Yes        No        Occasionally

Related to particular food or circumstances? \_\_\_\_\_

Do you use recreational drugs?    Yes        No

If yes, how often and what type? \_\_\_\_\_

Have you ever been treated for drug and/or alcohol dependency?    Yes        No

If yes, please circle which one.

### FAMILY HISTORY:

Hereditary Diseases: Use "F" for father, "M" for mother, "S" for sibling, "G" for grandparent, "O" for others

\_\_\_\_\_ Heart Disease                      \_\_\_\_\_ Diabetes                      \_\_\_\_\_ Allergies

\_\_\_\_\_ Hypertension                      \_\_\_\_\_ Arthritis                      \_\_\_\_\_ Mental Illness

\_\_\_\_\_ Intestinal Disease                      \_\_\_\_\_ Osteoporosis                      \_\_\_\_\_ Alcoholism

\_\_\_\_\_ Kidney Dysfunction                      \_\_\_\_\_ Ulcers                      \_\_\_\_\_ Asthma

\_\_\_\_\_ Gall Bladder Problems                      \_\_\_\_\_ Cancer, type: \_\_\_\_\_

Other (please list) \_\_\_\_\_

### FEMALES:

Are you or could you be pregnant?    Yes        No

Are you pre-menopausal or menopausal?    Yes        No

Are you experiencing any menopausal symptoms?    Yes        No

If yes, please specify \_\_\_\_\_

Have you had a bone density test?    Yes        No

If yes, what was the result? \_\_\_\_\_

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# LIFESTYLE ASSESSMENT FORM

Name: \_\_\_\_\_

## DIETARY HABITS:

How many times a day do you eat:

Main Meals \_\_\_\_\_ Times of day: \_\_\_\_\_

Snacks \_\_\_\_\_ Times of day: \_\_\_\_\_

Do you eat meals:      with family      home alone      on the run  
   restaurant      fast food

Do you feel there are restrictions to your diet due to the preferences of others -  
Family, roommates, etc?    Yes      No      If yes, explain \_\_\_\_\_

How many ½ cup servings of each do you typically eat in a day:

\_\_\_\_\_ Fruit:    Fresh      Dried      Canned

\_\_\_\_\_ Vegetables:    Cooked      Raw

\_\_\_\_\_ Whole Grains

\_\_\_\_\_ Protein: Type \_\_\_\_\_

\_\_\_\_\_ Dairy Products: Type \_\_\_\_\_

\_\_\_\_\_ Other: Specify \_\_\_\_\_

Give examples of your typical meals:

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

Do you eat or use (indicate "1" for rarely, "2" for regularly, "3" for often)

aluminum pans \_\_\_\_\_      margarine \_\_\_\_\_      candy \_\_\_\_\_

microwave \_\_\_\_\_      fried foods \_\_\_\_\_      refined foods \_\_\_\_\_

luncheon meats \_\_\_\_\_      cigarettes \_\_\_\_\_      fast foods \_\_\_\_\_

Nutra Sweet/Aspartame \_\_\_\_\_

Please indicate how many cups of the following you drink per day:

\_\_\_\_\_ bottled or spring water      \_\_\_\_\_ tap water      \_\_\_\_\_ milk (1% or 2%)

\_\_\_\_\_ fresh fruit juices      \_\_\_\_\_ beer      \_\_\_\_\_ milk (skim)

\_\_\_\_\_ fruit juices (prepared)      \_\_\_\_\_ red wine      \_\_\_\_\_ tea

\_\_\_\_\_ fresh vegetable juices      \_\_\_\_\_ white wine      \_\_\_\_\_ herbal tea

\_\_\_\_\_ soft drinks (regular)      \_\_\_\_\_ other alcoholic      \_\_\_\_\_ coffee

\_\_\_\_\_ soft drinks (diet)      other (specify) \_\_\_\_\_

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## LIFESTYLE ASSESSMENT FORM

Name: \_\_\_\_\_

Are you a:	meat eater?	vegetarian?	vegan?
How often do you eat meat?	daily	3-5/week	once/week or less
How often do you consume dairy products?	daily	3-5/week	once/week or less

What are your favourite foods? \_\_\_\_\_

How often do you eat them? \_\_\_\_\_

Do you avoid certain foods? If so, why?

\_\_\_\_\_  
\_\_\_\_\_

Do you experience any symptoms if meals are missed? Explain:

Do you experience any symptoms after meals? Explain:

Comments: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**CLIENT STATEMENT:**

I understand and acknowledge that the services provided are at all times restricted to consultation on the subject of health matters intended for general well-being, and are not meant for the purposes of medical diagnosis, treatment or prescribing of medicine for any disease, or any licensed or controlled act which may constitute the practice of medicine. This statement is being signed voluntarily.

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Name: \_\_\_\_\_  
(please print)

Address: \_\_\_\_\_

City: \_\_\_\_\_ Prov: \_\_\_\_\_ P.C.: \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (B) \_\_\_\_\_

*Thank you for your cooperation.  
All information contained on this form will be kept strictly confidential.*

# 1. THE DIGESTIVE SYSTEM

NOW PLEASE COMPLETE THE FOLLOWING QUESTIONNAIRES USING THE SAME RATING SYSTEM:

Leave blank if symptom or activity does not apply, 1 for mild or rarely occurring, 2 for moderate or regularly occurring, 3 for severe or often occurring.

Excessive gas, belching or burping after meals	
Stomach bloated after eating	
Sleepy after eating	
Longitudinal striations on fingernails	
Eat when rushed/in a hurry	
Halitosis	
Full feeling after heavy meat meal	
Heavy, tired feeling after eating	
Nausea after taking supplements	
Acne	
Undigested food in the stool	

Stomach pain 1 hour after eating or at night	
Burning sensation in stomach	
Pain aggravated by worry/tension	
Hiatal hernia	
Gastritis, gastric ulcer	
Nausea, vomiting	
Sensation of acidity in abdominal area	
Heartburn, indigestion	
Blood in stool	
Lower back pain	
Long term aspirin use	

Yellow or pale fingernails	
Skin oily on nose and forehead	
Fats/greasy foods cause nausea, headaches	
Vertical white streaks on fingernails	
Onions, cabbage, radishes, cucumbers cause bloating /gas	
Bad breath; bad taste in mouth	
Excess body odour	
High cholesterol/high cholesterol diet	
Stiff, aching muscles	
Migraine headaches	
Discomfort underneath right ribcage	
Food allergies	
Irritable, easily angered	
Weight gain around the abdomen	
Yellow palms	
Jaundice	
Poor concentration	
Difficulty losing weight	
Acne, boils, rashes, psoriasis or eczema	
Constipation	

Severe abdominal pain	
Nausea and vomiting	
Slow digestion; feel full for hours after eating	
Fever	
Alcohol addiction	
Jaundice	

Hungry up to 3 hours after eating	
Strong, sudden cravings for sweets, starches coffee or alcohol	
Nervous/anxious feelings relieved by eating	
Irritable if late for or skip a meal	
Overweight	
Addicted to coffee with sugar and/or colas	
Frequent "midnight snacks"	
Family history of diabetes	
Fatigue	
Frequent headaches	
Fainting spells	
Depression	
Lose temper easily	

Gall stones; history of gall stones	
Stool appears clay-coloured, foul odoured	
Constipation	
High cholesterol diet; High blood cholesterol levels	
Severe pain in right upper abdomen	

## 2. THE INTESTINAL SYSTEM

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

If any of the following symptoms or activities apply please indicate by checking:

1 - for mild or rarely occurring

3 - for severe or often occurring

2 - for moderate or regularly occurring

or leave blank - if the symptom / statement does not apply.

134	Extreme fatigue	
135	Recurrent vaginal infections	
136	Frequent use of antibiotics	
137	White coated tongue, oral thrush	
138	Crave sugars, bread, alcohol	
139	Headaches	
140	Tonsillitis, recurrent strep throat	
141	Itchy, watery or dry eyes	
142	Skin flushes	
143	Chronic indigestion, frequently use antacids	
144	Always cold especially in extremities	
145	Female : PMS	
146	Pain in pelvic area	
147	Abdominal gas and bloating	
148	Loss of sex drive	
149	Cystitis, repeated bladder infections	
150	Increasing food and chemical sensitivities: severe reaction to tobacco, perfume etc.	
151	Female: endometriosis/ovary problems	
152	Chronic diarrhea	
153	Hives, psoriasis, acne, skin rashes	
154	Rectal itching	
155	Abnormal muscle aches from exercise	
156	Excessive wax in ears	
157	Unexpected / unexplained weight gain	
158	Impotence	
159	Canker sores	
160	Athlete's foot, finger / toenail fungus, ringworm	
161	Jock itch	
162	"Brain fog"	
163	Irritability	

164	Memory loss	
165	Mental confusion	
166	Depression or anger for no reason	
167	Anxiety / panic attacks	
168	Inability to concentrate	
169	Phobic / compulsive	
170	Lethargy	
171	Mood swings	
172	Itchy ears, nose, anus	

173	Forgetfulness	
174	Slow reflexes	
175	Gas and bloating	
176	Unclear thinking	
177	Loss of appetite	
178	Yellowish or pale face	
179	Fast heartbeat	
180	Heart pain	
181	Pain in navel	
182	Eating more than normal but still feeling hungry	
183	Blurry or unclear vision	
184	Pain in the back, thighs, shoulders	
185	Numb hands	
186	Drooling while sleeping	
187	Damp lips at night	
188	Dry lips during the day	
189	Grind teeth while sleep	
190	Bedwetting	
191	Lethargy, chronic fatigue	
192	Dark circles under eyes	
193	Cancer	

## 5. THE LYMPHATIC / IMMUNE SYSTEMS

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

If any of the following symptoms or activities apply please indicate by checking:

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

194	Excessive sleep	
195	Very susceptible to infections	
196	Swollen glands: tonsils, throat, armpits	
197	History of cancer, MS, Parkinson's, arthritis	
198	Loss of appetite	
199	Headaches	
200	Soreness on both sides of neck at shoulder	
201	Feel puffiness in throat	
202	Look older than chronological age	
203	Flu-like symptoms often occur	
204	Lupus	

205	Acne, psoriasis, dermatitis, eczema	
206	Rapid pulse, heart irregularities	
207	Frequent headaches	
208	Hay fever	
209	Frequent cravings for certain foods	
210	Periods of blurred vision	
211	Repeated ear trouble	
212	Hyperactivity	
213	Dizzy spells	
214	Periods of confusion	
215	Poor concentration	
216	Epilepsy	
217	Muscle cramps or spasms	
218	Abnormal body odour	
219	Excessive sweating, night sweats	
220	Bowel disease: IBS, IBD, Crohn's etc.	
221	Joint pains or stiffness	
222	Frequent night urination	
223	Wheezing	
224	Pale face	
225	Hives	
226	Nose runs constantly	
227	Noticeable changes in writing throughout the day	
228	Nosebleeds	
229	Bloating or gas after eating certain foods	
230	Canker sores	
231	Dark circles under eyes	
232	Stuffy nose	

## 8. THE GLANDULAR / ENDOCRINE SYSTEMS

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

If any of the following symptoms or activities apply please indicate by checking:

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

233	Distinct lethargic tiredness or sluggishness	
234	Cold hands or feet	
235	Mercury amalgams (fillings)	
236	Gain weight easily, fail to lose on diets	
237	Constipation (less than one bowel movement a day)	
238	Low energy in the morning	
239	Low pulse rate	
240	Low body temperature, especially at bed rest	
241	Hair dry, brittle, dull, lifeless	
242	Flaky, dry, rough skin	
243	Feel stiff after sitting still for some time	
244	Mood swings	
245	Unusually square and wide fingernails	
246	High cholesterol	
247	Diminished sex drive	

259	Losing weight without trying	
260	Heart races while at rest	
261	Feel warm/flushed at room temperature	
262	Hands shake or tremble	
263	Protruding tongue	
264	Heart palpitations	
265	Nervous behaviour, hyperactivity	
266	Insomnia	
267	Increased appetite	
268	Frequent bowel movements, diarrhea	
269	Excessive sweating without exercising	

248	Infertility or impotence	
249	Headaches affecting one side of the head	
250	Female: loss of menstrual function	
251	Moody	
252	Overweight from waist down	
253	Overweight from waist up	
254	Excessive urination	
255	Pain in little finger of left hand	
256	Swelling in ankles, fingers, feet	
257	Cold hands or feet	
258	Pain in left side of upper neck	

270	Stress or emotional upsets cause exhaustion	
271	Blood pressure decreases when going from a lying position to a standing position	
272	Perspire excessively	
273	Neck and / or shoulder tension	
274	Frequent headaches	
275	Bow lines (depressed furrows) on fingernails	
276	Occasional cold sweats	
277	Tightness or lump in throat, especially when emotionally disturbed	
278	High or low blood pressure	
279	Rapid pulse	
280	Short temper	
281	Puffy face	

## 9. THE STRUCTURAL-MUSCULAR / SKELETAL SYSTEM

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

If any of the following symptoms or activities apply please indicate by checking:

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

282	Pain, swelling, stiffness in joints	
283	Joint inflammation (rheumatoid arthritis)	
284	Pain, stiffness, inflammation of spine	
285	Facial pain	
286	Joints make popping sounds	
287	Joints make sounds like crinkling cellophane	
288	Gout	
289	Ankylosing spondylitis	
290	Bones fracture easily	
291	Gradual loss of height	
292	Tooth loss; teeth "falling out"	
293	Lack of exercise	
294	Rounding of shoulders; stooping	
295	Female: Menopause	
296	Pain in forearm or biceps	
297	Cramps in calf muscle during sleep or exercise	
298	Painful cramping of feet or toes	
299	Teeth prone to decay, frequent toothaches	
300	Malformation of bones	
301	Insomnia	
302	Muscles weak, weak grip, light objects feel heavy	
303	Heart palpitations	
304	Diets high in animal foods (meat, dairy, eggs)	

305	Muscle pain	
306	Muscle weakness	
307	Sprains; muscle strains	
308	Muscle(s) spasm	

309	Muscles wasting in some part of the body	
310	Numbness or loss of sensation	
311	Mood swings and / or depression	
312	Blurred or double vision	
313	Tingling and / or numbness, especially in extremities	
314	Loss of balance and / or coordination	
315	Muscular stiffness	
316	Difficulty breathing	
317	Male: impotence	
318	Tremors	
319	Loss of peripheral vision	
320	Slurred speech	
321	Objects fall from hands, reach in wrong place	
322	Hands tremble	
323	Impaired speech	