NUTRITION SYSTEM PROFILE (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, 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	Use this column only.		1	2	3	4	5	6	7	8	9	10
1	General Fatigue or Weakness												
2	Difficulty losing weight												
3	Frequent Illness or Infection												
4	High Stress Lifestyle												
5	Smoking												
6	Drink more than 2 cups coffee per day												
7	Bad Breath/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/Burping after meals												
16	Skin/complexion problem												
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 or Irritable												
23	Brittle fingernails												
24	Dry, Brittle Hair												
25	High Fat Diet												
26	Nervous or Anxious												
27	Insomnia or Restless sleep												
28	Low Fibre Diet												
29	Muscle Cramps												
30	Sleepy when sitting up												
	SUB TOTAL												

	SUB TOTAL PAGE 1			1	2	3	4	5	6	7	8	9	10
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												
41	Excessive mucous												
42	Short of breathe 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 inflamation/ 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												

	TOTAL SCORES											