

**The
NUTRI-SYSTEMS
PROFILE
(NSP)**

Nutritional Assessment by Body Systems

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											
	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.)

<i>Please complete this section</i>			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 TOTAL												

Right Side for Office Use Only

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	