

FIT Into *Health*

NUTRITIONAL SYSTEMS PROFILE

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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	Drink 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 fiber 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										
TOTAL SCORES											

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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.

UNDERACTIVE STOMACH

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	

OVERACTIVE STOMACH

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	

LIVER:

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 odor	
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	

PANCREAS:

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

HYPOGLYCEMIA:

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 BLADDER:

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

2. THE INTESTINAL 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.

CANDIDIASIS:

Extreme fatigue	
Recurrent vaginal infections	
Frequent use of antibiotics	
White coated tongue, oral thrush	
Crave sugars, bread, alcohol	
Headaches	
Tonsillitis, recurrent strep throat	
Itchy, watery or dry eyes	
Skin flushes	
Chronic indigestion, frequently use antacids	
Always cold, especially in extremities	
F: PMS	
Pain in pelvic area	
Abdominal gas and bloating	
Loss of sex drive	
Cystitis, repeated bladder infection	
Increasing food and chemical sensitivities; severe reaction to tobacco, perfume, etc.	
F: endometriosis/ovary problems	
Chronic diarrhea	
Hives, psoriasis, acne, skin rashes	
Rectal itching	
Abnormal muscle aches from exercise	
Excessive wax in ears	
Unexpected/unexplained weight gain	
Impotence	
Canker sores	
Athlete's foot, finger/toenail fungus, ringworm	
Jock itch	
"Brain fog"	
Irritability	
Memory loss	
Mental confusion	
Depression or anger for no reason	
Anxiety/panic attacks	
Inability to concentrate	
Phobic/compulsive	
Lethargy	
Mood swings	
Itchy ears, nose, anus	

PARASITES:

Forgetfulness	
Slow reflexes	
Gas and bloating	
Unclear thinking	
Loss of appetite	
Yellowish or pale face	
Fast heartbeat	
Heart pain	
Pain in the navel	
Eating more than normal but still feeling hungry	
Blurry or unclear vision	
Pain in the back, thighs, shoulders	
Numb hands	
Drooling while sleeping	
Damp lips at night	
Dry lips during the day	
Grind teeth while asleep	
Bedwetting	
Lethargy, chronic fatigue	
Dark circles under eyes	
Cancer	

5. THE LYMPHATIC / IMMUNE 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.*

THYMUS (IMMUNITY):

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

ALLERGIES:

Acne, psoriasis, dermatitis, eczema	
Rapid pulse, heart irregularities	
Frequent headaches	
Hay fever	
Frequent cravings for certain foods	
Periods of blurred vision	
Repeated ear trouble	
Hyperactivity	
Dizzy spells	
Periods of confusion	
Poor concentration	
Epilepsy	
Muscle cramps or spasms	
Abnormal body odor	
Excessive sweating, night sweats	
Bowel disease: IBS, IBD, Crohn's, etc.	
Joint pains or stiffness	
Frequent night urination	
Wheezing	
Pale face	
Hives	
Nose runs constantly	
Noticeable changes in writing throughout day	
Nosebleeds	
Bloating or gas after eating certain foods	
Canker sores	
Dark circles under eyes	
Stuffy nose	

8. THE GLANDULAR / ENDOCRINE 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.

UNDERACTIVE THYROID/HYPOTHYROID:

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

OVERACTIVE THYROID/HYPERTHYROID :

Losing weight without trying	
Heart races while at rest	
Feel warm/flushed at room temperature	
Hands shake or tremble	
Protruding tongue	
Heart palpitations	
Nervous behaviour, hyperactivity	
Insomnia	
Increased appetite	
Frequent bowel movements, diarrhea	
Excessive sweating without exercising	

PITUITARY:

Infertility or impotence	
Headaches affecting one side of head	
F: loss of menstrual function	
Moody	
Overweight from waist down	
Overweight from waist up	
Excessive urination	
Pain in little finger of left hand	
Swelling in ankles, fingers, feet, or under	
Cold hands or feet	
Pain in left side of upper neck	

ADRENALS:

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

9. THE STRUCTURAL - MUSCULAR/SKELETAL 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.

SKELETAL:

Pain, swelling, stiffness in joints	
Joint inflammation (rheumatoid arthritis)	
Pain, stiffness, inflammation of spine	
Facial pain	
Joints make popping sounds	
Joints make sounds like crinkling cellophane	
Gout	
Ankylosing spondylitis	
Bones fracture easily	
Gradual loss of height	
Tooth loss; teeth "falling out"	
Lack of exercise	
Rounding of shoulders; stooping	
F: Menopause	
Pain in forearm or biceps	
Cramps in calf muscle during sleep or exercise	
Painful cramping of feet or toes	
Teeth prone to decay, frequent toothaches	
Malformation of bones	
Insomnia	
Muscles weak, weak grip, light objects feel heavy	
Heart palpitations	
Diet high in animal foods (meat, dairy, eggs)	

NEUROMUSCULAR:

Muscles wasting in some part of the body	
Numbness or loss of sensation	
Mood swings and/or depression	
Blurred or double vision	
Tingling and/or numbness, especially in extremities	
Loss of balance and/or coordination	
Muscular stiffness	
Difficulty breathing	
M: impotence	
Tremors	
Loss of peripheral vision	
Slurred speech	
Objects fall from hands, reach in wrong place	
Hands tremble	
Impaired speech	

MUSCULAR:

Muscle pain	
Muscle weakness	
Sprains; muscle strains	
Muscle(s) spasm	

Privacy Policy Consent Form

Consent Declaration

My office understands the importance of protecting your personal information. I have outlined below how the office is using and disclosing your information.

This office will gather, use and disclose only necessary information about you for the following purposes:

- To research information for nutritional and dietary assessments of imbalances
- To collect RNCP consultation fees
- Newsletters
- Emailing of Education, wellness, and health-related topics
- Seminars, workshops and surveys to promote nutritional consulting

DISCLOSURE:

- To a specific doctor who you are working with
- To an emergency service if one's life could be endangered

I will only share your information with your consent. Storage, retention and destruction of your personal information complies with existing legislation, and privacy protocols.

I am trained in the appropriate uses and protection of your information.

Client Acceptance

I agree to this office collecting, using and disclosing personal information about me as outlined above:

DATE:

PRINTED
NAME:

SIGNATURE

NUTRITIONAL EVALUATION CLIENT STATEMENT

*for the exclusive use of Registered Nutritional Consulting Practitioners,
who are Professional Members of the International Organization of Nutritional Consultants*

I hereby attest to the following:

1. That I am here on this, and any subsequent visit, solely on my own behalf and not as an agent for any federal, provincial or municipal agency on a mission of entrapment or investigation.
2. I fully understand that Registered Nutritional Consulting Practitioners (RNCs) are not medical doctors, and I am not here for medical diagnostic or treatment procedures. If I have any health problem, health condition, or disease, I am now being advised not to postpone or delay getting competent medical advice from a licensed doctor of medicine. I understand and agree that any services rendered by an RNC is not designed to cure or prevent any disease, pain, deformity, injury or mental or physical condition of any kind. I am here to learn how to do this for myself.
3. The services performed by an RNC is at all times restricted to consultation on the subject of nutrition intended for building wellness and does not involve the diagnosing, prognosticating, treatment, or prescribing of remedies for the treatment of disease, or for any act for which a medical licence is required.
4. Most doctors leave nutrition alone because they have not studied nutrition in great depth. We leave disease alone because we are not licensed to treat disease. However, we can recommend what we would do regarding diet improvements to facilitate normal physical and spiritual health. If, as a consequence, your diseases should diminish, then so much the better.
5. In natural healing methods, it is not necessary to pinpoint diseases. Nature heals when the body is normalized and natural foods and supplements are taken in place of toxin-producing substances. We believe it is not important to name diseases. It is much more important to start individuals back on the road to proper nutrition and other healthful habits.
6. This agreement is being signed voluntarily and not under duress of any kind.

Signed _____ Date _____

Print Name _____

Address _____ City _____

Postal Code _____ Phone (h) _____ (w) _____

Fax _____ E-mail _____

Age _____ Weight _____ Height _____ Occupation _____

Referred by _____