Fruit of the Womb, LLC
BCST Client Self-Assessment

Name _____ **Date** _____

Please mark on the images below any areas where you are currently feeling sensations of restriction, congestion, blockage or discomfort:

For the following questions "1" indicates lowest, "10" indicates highestt:

How is your level of pain? 1 2 3 4 5 6 7 8 9 10

How is your level of stress? 1 2 3 4 5 6 7 8 9 10

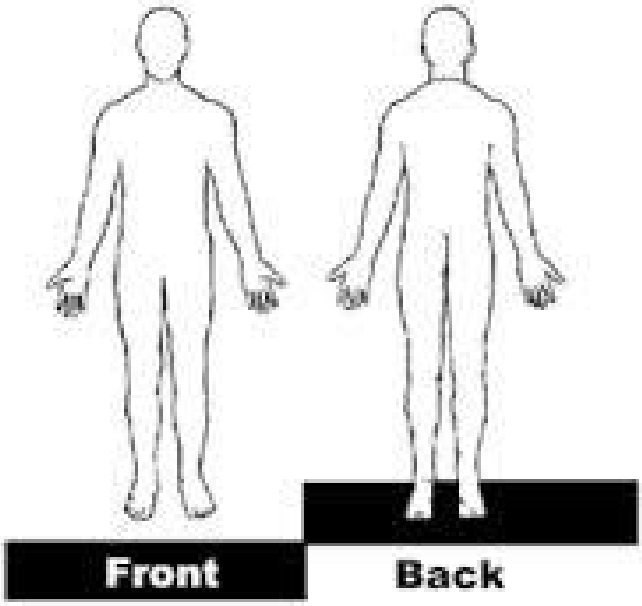
How is the quality of your sleep? 1 2 3 4 5 6 7 8 9 10

How is the quality of your digestion? 1 2 3 4 5 6 7 8 9 10

How is your sense of wellbeing ~

physical: 1 2 3 4 5 6 7 8 9 10 **emotional :**1 2 3 4 5 6 7 8 9 10

mental: 1 2 3 4 5 6 7 8 9 10 **overall :** 1 2 3 4 5 6 7 8 9 10



Notes_____