Client Self Reassessment:

Name___________________________________ Date_______________

Please mark any areas where you are currently feeling sensations of restriction, congestion, blockage or discomfort:
For the following questions "1" indicates lowest/worst, "10" indicates highest/best:

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

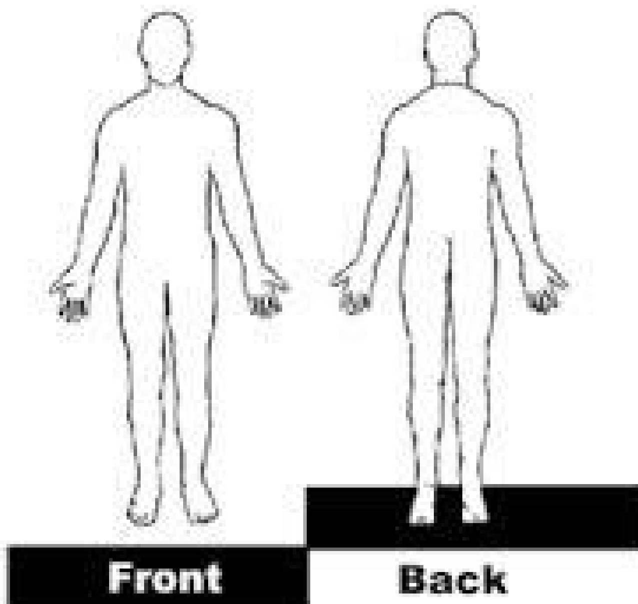
How is the quality of your sleep? 1 2 3 4 5 6 7 8 9 10

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

What is your impression of your condition now, relative to when you began receiving BCST?



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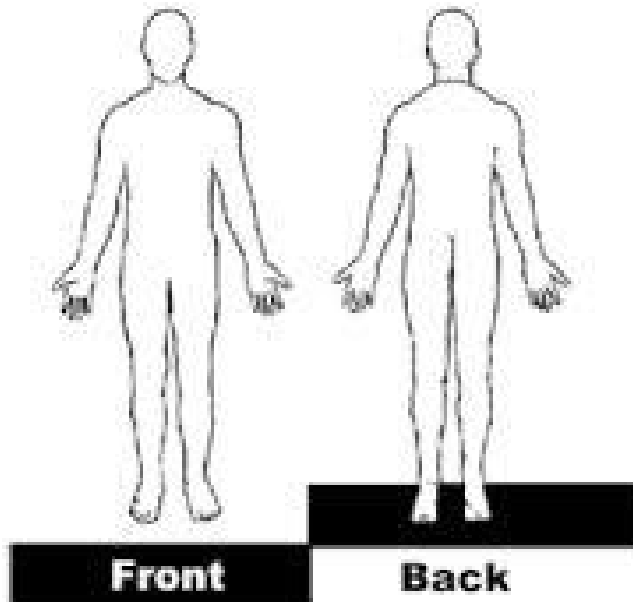

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