Functional Integrative Practice of Dr. Nadia Ali
Functional Holistic Healing
175 Strafford Ave, Suite one
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POST IASIS 24/48 Hour Assessment Form

Name:_____ **Date:**_____
Session#_____

My five most prominent symptoms are:

1. No Change Improved Significant Improvement
2. No Change Improved Significant Improvement
3. No Change Improved Significant Improvement
4. No Change Improved Significant Improvement
5. No Change Improved Significant Improvement

Please note any improvement in the following categories:

➢ **My Energy Level has : Increased Decreased Same**

Duration : Longer Shorter Same

Describe:_____
_____

➢ **My Sleep has: Increased Decreased Same**

Quality : Better Reduced Same

Duration : Longer Shorter Same

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Describe:_____
_____

➢ **My Anxiety has: Increased Decreased Same**

Describe:_____
_____

➢ **My appetite is: Better Same Decreased**

Describe:_____
_____

➢ **My thinking is more: Clear Same Less Clear**

Describe:_____
_____

➢ **My Mind is : Quieter Same More Wired**

Describe:_____
_____

➢ **My Headaches have: Decreased Same Increased**

Describe:_____
_____

➢ **I have noticed a: :Decrease in Temp No Change Increase in Temp**

Describe:_____
_____

➢ **My posture: Less Improved Improved No Change**

Describe:_____
_____

➢ **Any Other Changes Noted:**
Describe:_____