



Name: _____ Date: _____

Section A

Do you remember being bitten by a tick? ___ Yes ___ No. If yes, when? _____

Do you remember having the "bull's eye" rash? ___ Yes ___ No

Do you have any other rash? ___ Yes ___ No. If yes, describe: _____

Please Check all "Yes" Answers:

- ___ Spend time in Tick-infested area
- ___ Frequent outdoor activities
- ___ Hiking
- ___ Fishing
- ___ Camping
- ___ Gardening
- ___ Hunting
- ___ Ticks noted on pets

Section B:

Please check which symptoms you have experienced:

- Unexplained fevers, night or day sweats, chills
- Unexplained weight change (loss or gain)
- Fatigue, tiredness, poor stamina
- Unexplained hair loss
- Swollen glands (list areas _____)
- Sore throat
- Testicular pain/pelvic pain
- Unexplained menstrual irregularity
- Unexplained milk production; breast pain
- Irritable bladder or bladder dysfunction
- Sexual dysfunction or loss of libido
- Upset stomach
- Change in bowel function (constipation, diarrhea)
- Chest pain or rib soreness
- Shortness of breath, cough
- Heart palpitations, pulse skips, heart block
- Any history of a heart murmur or valve prolapse
- Joint pain or swelling (list joints _____)
- Stiffness of the joints (ie. neck, back)
- Muscle pain or cramps
- Twitching of the face or other muscles
- Headache
- Neck creaking and cracking, neck stiffness, neck pain
- Tingling, numbness, burning/stabbing sensation, shooting pains
- Facial paralysis (Bell's palsy)
- Eyes/Vision: double, blurry, increased floaters, light sensitivity
- Ears/Hearing: buzzing, ringing, ear pain, sound sensitivity
- Increased motion sickness, vertigo, poor balance
- Lightheadedness, wooziness
- Tremor
- Confusion, difficulty in thinking
- Difficulty with concentration, reading
- Forgetfulness, poor short-term memory
- Disorientation: getting lost going to wrong places
- Difficulty with speech, vocalization, or writing; word block
- Mood swings, irritability, depression
- Disturbed sleep-too much, too little, fractionated, early awakening
- Exaggerated symptoms or worse hangover from alcohol

Total: _____ / 38

Section C:

- | | |
|-----------------------------------------------------------------------|------------------------------------------------------------|
| <input type="checkbox"/> High fever and chills at the onset symptoms. | <input type="checkbox"/> Cough |
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Persistent migraine-like headache |
| <input type="checkbox"/> Air hunger | <input type="checkbox"/> Sense of imbalance |
| | <input type="checkbox"/> Fatigue |

Total: ____ / 7

Section D:

- | | |
|--------------------------------------------------------------------------------|-----------------------------------------------------------|
| <input type="checkbox"/> Neurological symptoms more severe than other symptoms | <input type="checkbox"/> Lower abdominal pain |
| <input type="checkbox"/> Agitation | <input type="checkbox"/> Sore soles |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Sore soles worst in morning |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Red rashes |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Red streaking like stretch marks |
| <input type="checkbox"/> Difficulty with mental processing | <input type="checkbox"/> Lymph nodes enlarged |
| | <input type="checkbox"/> Sore throat |

Total: ____ / 13

Section E:

- | | |
|-------------------------------------------|-------------------------------------------------------------------------------------------|
| <input type="checkbox"/> High Fever | <input type="checkbox"/> Shooting pains |
| <input type="checkbox"/> Severe Headache | <input type="checkbox"/> Abnormalities in liver function, white blood cells, or platelets |
| <input type="checkbox"/> Chronic headache | |
| <input type="checkbox"/> Muscle symptoms | |

Total: ____ / 6

Section F:

- | | |
|--------------------------------------|------------------------------------------------------------|
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Difficulty with mental processing |
| <input type="checkbox"/> Joint Pain | <input type="checkbox"/> High fever |
| <input type="checkbox"/> Muscle pain | |

Total: ____ / 5

Section G:

- | | |
|--------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Dark spotted rash | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Muscle Ache |
| <input type="checkbox"/> High fever | <input type="checkbox"/> Light sensitivity |
| <input type="checkbox"/> "Brain Fog" | |

Total: ____ / 7

Sources:

- Burrascano, Joseph. Managing Lyme Disease, 15th ed. September 2005.
- Burrascano, Joseph. Advanced Topics in Lyme Disease: Diagnostic Hints and Treatment Guidelines for Lyme and Other Tick Borne Illnesses, 13th ed. May 2000.
- Singleton, Kenneth M.D. "The Lyme Disease Solution." 2008.