

Name: _____ Date: _____

Lyme Disease Supplemental Intake Form

This is not meant to be used as a diagnostic tool but is provided to streamline the office interview.

Risk: (Please check all that apply)

Tick infested area ___ Frequent outdoor activities ___ Hiking ___ Fishing ___ Camping ___

Gardening ___ Hunting ___ Farming ___ Ticks on pets ___

Do you remember a tick bite? No ___ Yes ___ When? _____

Do you remember a "bull's eye" rash? No ___ Yes ___ When? _____

Other rash? No ___ Yes ___ When? _____

Have you received the Lymerix vaccine? No ___ Yes ___ When? _____

Please rate the following in severity from 0 = none to 10 = worst.

Symptom	Past	Now			
Unexplained fevers, sweats, chills, flu-like					
Joint pain or swelling. List joints:					
Muscle pain or cramping. List muscles:					
Tingling, numbness					
Burning, stabbing pain					
Headaches. List where:					
Neck pain or stiffness					
Fatigue					
Sore throat					
Muscle twitching					
Tremors					
Facial paralysis (Bells Palsy)					
Blurry or double vision, difficulty reading					
Eye pain					
Testicular pain					
Lightheaded, dizziness, vertigo					
Poor balance					
Difficulty walking					
Brain fog, poor memory/concentration, confusion					
Difficulty with speech or writing					
Disorientation: getting lost					
Sleep problems					
Depression, anxiety, mood swings					
Symptoms worse after exertion or alcohol use					
Chest pain					
Air hunger, shortness of breath					
Heart palpitations, flutter, skipped beats					
Night sweats					
Sole pain (bottoms of feet)					
Swollen glands. List where:					
Cough					
Other:					
Rate your overall health from 0-100%					

UnRegistered