Kingston Integrated Healthcare

Dr. Sonya Nobbe, Doctor of Naturopathic Medicine

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LYME DISEASE SCREENING INTAKE

Name: _____ _____Date: _____

Date of birth (dd/mm/yy): _____Age: _____Gender: _____

Please list your primary symptoms, in order of importance:

1._____ Date of onset: _____

2._____ Date of onset: _____

3._____ Date of onset: _____

SYMPTOM TIMELINE

Create a timeline of all symptoms, illnesses, and events that ***may*** correspond to your current illness. Include date of tick or insect bite (if known), unusual rashes, flu symptoms, times when additional symptoms started, stopped, aggravated, or improved. Use additional paper if necessary.

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____
4. _____ Date: _____
5. _____ Date: _____
6. _____ Date: _____
7. _____ Date: _____
8. _____ Date: _____

Please list **all pharmaceuticals** administered from 3 months before the onset of symptoms, to the present. Include vaccinations, antibiotics, steroids (e.g. sprays, inhalers), and pain medication:

1. _____ Date started: _____ Dose: _____
2. _____ Date started: _____ Dose: _____
3. _____ Date started: _____ Dose: _____
4. _____ Date started: _____ Dose: _____
5. _____ Date started: _____ Dose: _____
6. _____ Date started: _____ Dose: _____
7. _____ Date started: _____ Dose: _____

LABORATORY INVESTIGATION

Please bring copies of all recent and/or relevant test results and imaging reports (e.g. ultrasound, MRI, CT, chest xray). You can ask for copies from your family doctor, or we can send your family MD a Release of Records, following our initial appointment. Some of these tests we may decide to conduct ourselves.

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EXPOSURE

Please list your employment history and current occupation: _____

_____

Please list your travel history: _____

_____

Would you consider yourself an outdoors person (please describe): _____

_____

Have you ever knowingly been bitten by a tick? Spider? _____

What (if any) pets reside in the home or were you exposed to at the time of symptom onset? _____

_____

SUSCEPTIBILITY

How robust would you say your immune system is (please describe)? _____

_____

Did you experience a significant injury, physical or emotional trauma, or surgery (including dental), weeks to months prior to the onset of your illness? _____

_____

_____

How many times have you used antibiotics? _____

Please list any allergies or sensitivities (e.g. to medications, food, scents, mold): _____

_____

Have you ever been chronically exposed to heavy metals? (Please see Self-Assessment on our website for more guidance. Consider places you've lived, food you've consumed regularly, dental amalgams, cigarette smoke.) _____

_____

Have you ever been chronically exposed to toxic chemicals (e.g. pesticides on farmland, industrial pollution, etc.)? _____

Have you ever been chronically exposed to mold? _____

_____

Please check all that apply regarding **your entire medical history**:

☐ Blood clots (e.g. DVT, stroke, heart attack)	☐ Significant anxiety, depression, or mood swings
☐ Cancer	☐ Recurrent fungal or yeast problem
☐ Chronic allergies or hives	☐ Fibromyalgia or Chronic Fatigue Syndrome
☐ Physical congenital defect (e.g. cleft palate)	☐ Osteoporosis
☐ Concerns regarding fertility or pregnancy	☐ Gout

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PAIN SYMPTOMS

When considering your pain, *thoroughly* explore what makes it better or worse, including application of heat, cold, time of day, movement, prolonged sitting, stress, etc. Do a **full body-scan** and list all places where pain *regularly* occurs.

	Where is it? **When did it start?** **What does it feel like**?	**What makes it better?** (e.g. application of hot, cold, morning vs. night)	**What makes it worse?** (e.g. menstrual cycle timing, damp weather)
Headaches, neck pain, and migraines			
Joint pain (e.g. jaw, knees, ribs, swelling)			
Muscle pain			
Nerve pain (e.g. sharp, shooting)			
Other:			

NERVOUS SYSTEM SYMPTOMS

	Describe:	**What makes it better?**	**What makes it worse?**
Skin burning, tingling, twitching, numbness			
Facial paralysis (e.g. Bell's Palsy)			
Muscle twitches, tremors			
Insomnia and disturbed sleep			
Fatigue			
Mood changes (e.g. anger, anxiety)			
Brain changes (e.g. forgetfulness, focus)			
Dizziness, light-headedness, vertigo			
Other:			
Other:			

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CARDIOVASCULAR & LUNG SYMPTOMS

	Describe:	Date of onset:	What makes it better or worse?
Heart palpitations (i.e. can feel heart beat)			
Fast, slow or irregular heart rate			
Chronic cold hands or feet (e.g. Raynaud's)			
High or low blood pressure			
Shortness of breath or difficulty breathing			
Chronic, unexplained cough			
Other:			

Please check all that apply *since the onset* of your illness:

O Tooth pain or sensitivity
O Nightsweats, day sweats
O Recurring chills or fever
O Severe, unexplained fatigue
O Muscle pain *comes and goes*
O Joint pain *comes and goes*
O Tingling/burning/ numbness *comes and goes*
O Ear ringing or buzzing
O Recurring nausea
O Skin rash, "lumps", ulcers
O Skin "crawling"sensations
O Skin "stretch" marks
O Irritable bladder
O Swollen lymph nodes
O Other:

FAMILY HEALTH HISTORY

Please indicate whether the following health conditions pertain to **your family members or spouse**:

Condition	Relative	Age of Onset	Details
Lyme disease or co-infection diagnosis or suspicion			
Heart or blood problems			
Nervous system problems (e.g. seizures)			
Cancer			
Digestive illness (e.g. Celiac, Crohn's, Colitis)			
Autoimmune disease (e.g. Rheumatoid arthritis, MS			
Other			

Thank you.