**Xu Wellness Center**

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[www.XuWellnessCenter.com](http://www.XuWellnessCenter.com)

**Lyme Disease Form**

|  |  |
| --- | --- |
| Name | Date |
| Mobile Phone | Mobile Provider | Date of Birth |
| Email | Social Security Number |

**Please Check if Each Symptom is Mild, Moderate, or Severe. Leave blank if you experience no symptom.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Symptom** | **Mild** | **Moderate** | **Severe** |
| Unexplained Fevers, Sweats, Chills, or Flushing |  |  |  |
| Unexplained Weight Change; Loss or Gain |  |  |  |
| **Fatigue, Tiredness** |  |  |  |
| Unexplained Hair Loss |  |  |  |
| Swollen Glands |  |  |  |
| Sore Throat |  |  |  |
| Testicular or Pelvic Pain |  |  |  |
| Unexplained Menstrual Irregularity |  |  |  |
| Unexplained Breast Milk Production; Breast Pain |  |  |  |
| Irritable Bladder or Bladder Dysfunction |  |  |  |
| Sexual Dysfunction or Loss of Libido |  |  |  |
| Upset Stomach |  |  |  |
| Change in Bowel Function (Constipation or Diarrhea) |  |  |  |
| Chest Pain or Rib Soreness |  |  |  |
| Shortness of Breath or Cough |  |  |  |
| Heart Palpitations, Pulse Skips, Heart Block |  |  |  |
| **Symptom** | **Mild** | **Moderate** | **Severe** |
| History of a Heart Murmur or Valve Prolapse |  |  |  |
| **Joint Pain or Swelling** |  |  |  |
| Stiffness of the Neck or Back |  |  |  |
| Muscle Pain or Cramps |  |  |  |
| Twitching of the Face or Other Muscles |  |  |  |
| Headaches |  |  |  |
| Neck Cracks or Neck Stiffness |  |  |  |
| **Tingling, Numbness, Burning, or Stabbing Sensations** |  |  |  |
| Facial Paralysis (Bell’s Palsy) |  |  |  |
| Eyes/ Vision: Double, Blurry |  |  |  |
| Ears/ Hearing: Buzzing, Ringing, Ear Pain |  |  |  |
| Increased Motion Sickness/ Vertigo |  |  |  |
| Light- Headedness, Poor Balance, Difficulty Walking |  |  |  |
| Tremors |  |  |  |
| Confusion, Difficulty Thinking |  |  |  |
| Difficulty with Concentration or Reading |  |  |  |
| **Forgetfulness, Poor Short-Term Memory** |  |  |  |
| Disorientation: Getting Lost, Going to Wrong Places |  |  |  |
| Difficulty with Speech or Writing |  |  |  |
| Mood Swings, Irritability, Depression |  |  |  |
| **Disturbed Sleep: Too Much, Too Little, Early Awakening** |  |  |  |
| Exaggerated Symptoms or Worse Hangover from Alcohol |  |  |  |
| **SUB-TOTALS (For Office Use Only)** |  |  |  |
| **Additional Points****(Office Use Only)** |  |

**Please Check Yes or No for the Following Questions**

|  |  |  |
| --- | --- | --- |
| **Questions** | **Yes** | **No** |
| Have you had a tick bite with no rash or flulike symptoms? |  |  |
| Have you had a tick bite, an erythema migrans, or an undefined rash, followed by flulike symptoms? |  |  |
| Do you live in what is considered a Lyme-Endemic area? |  |  |
| Do you have a family member who has been diagnosed with Lyme and/or other tick-borne infections? |  |  |
| Do you experience migratory muscle pain? |  |  |
| Do you experience migratory joint pain? |  |  |
| Do you experience tingling/ burning/ numbness that migrates and/ or comes and goes? |  |  |
| Have you received a prior diagnosis of chronic fatigue syndrome or fibromyalgia? |  |  |
| Have you received a prior diagnosis of a specific autoimmune disorder (lupus, MS, or rheumatoid arthritis), or of a nonspecific autoimmune disorder? |  |  |
| Have you had a positive Lyme test (IFA, ELISA, Western Blot, PCR, and/ or borrelia culture)? |  |  |
| **SUB-TOTAL (For Office Use Only)** |  |

**Overall Health Questions**

1. For how many of the past 30 days was your physical health not good? \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. For how many of the past 30 days was your mental health not good? \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Office Use Only) Sub-Total: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Signature X \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**For Office use Only**

Section 1 Total: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Section 2 Total: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Section 3 Total: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Section 4 Total: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Grand Total:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_