

Symptoms Checklist

Name _____ Date _____

**OFFICE
USE
ONLY**

Do You Have Or Have You Had Any Of The Following

If you experience a listed problem, please insert a number 1-5 in the box corresponding to the frequency of your symptoms: 1 being minimal and 5 severe.	Y E S	N O	C O N S T A N T	D A I L Y	W E E K L Y	M O N T H L Y	R A R E L Y	Comments	Tyne	Babesia or WAI	Ehrlichia	Bartonella	Mercury/Heavy M
General Well Being													
1. Unexplained weight loss or gain (circle), amount # _____													
2. Extreme Fatigue													
3. Swollen Glands: List areas _____ _____													
4. Continual infections (sinus, kidney, eye, etc.)													
5. Experienced a flu like illness, after which you have not felt well since													
6. Symptoms seem to change, come and go													
7. Pain migrates (moves) to different parts of the body													
8. Exaggerated symptoms or worse hangover from alcohol													
9. Chronic pain: list areas _____ _____													
10. Tooth pain													
11. Nose Bleeds													
12. Allergies													
Head – Face - Neck													
13. Unexplained hair loss													
14. Headaches													
15. Twitching of facial or neck muscles													
16. Facial paralysis (Bell's Palsy)													
17. Tingling of nose, cheek, or face													
18. Stiff or painful neck													
19. Jaw pain or stiffness													
20. Sore throat													
Eyes/Vision													
21. Double or blurry vision													
22. Increased floating spots													
23. Pain in eyes													
24. Swelling around eyes													
25. Oversensitive to light													
26. Sensitivity to flashing lights													
27. Blind spots													
28. Nightblindness													
Page 1 Subtotal													

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Ears / Hearing													
29. Decreased hearing in one or both ears													
30. Buzzing or ringing in ears													
31. Pain in ears													
32. Dizziness													
33. Motion sickness													
Digestive and Excretory													
34. Diarrhea													
35. Constipation													
36. Irritable bladder (trouble starting or stopping)													
37. Upset stomach, nausea or vomiting													
Musculoskeletal System													
38. Joint pain or swelling; list joints _____													
39. Stiffness of joints, back, neck													
40. Muscle pain or cramps													
41. Muscle tightness													
42. Feeling like your bones hurt													
43. Have you been diagnosed as having arthritis?													
Respiratory and Circulatory Systems													
44. Shortness of breath													
45. Chest pain or rib soreness													
46. Heart seems to have extra beats or racing pulse													
47. Any history of heart problems													
48. Loss of sex drive													
49. Unexplained menstrual pain													
50. Unexplained breast pain													
51. Unexplained milk production													
52. Testicular or pelvic pain													
Temperature Control													
53. Body temperature fluctuations													
54. Flushing													
55. Intolerance to heat or cold													
56. Decreased body temperature (below 98 ⁰)													
57. Low grade fevers													
58. Night sweats													
59. Chills													
Page 2 Subtotal													

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Neurologic System													
60. Headaches / migraine													
61. Pressure in head													
62. Numbness anywhere													
63. Tingling or pinprick sensations													
64. Burning sensations													
65. Crawling sensations under the skin													
66. Stabbing sensations													
67. Tremors													
68. Twitching													
69. Fainting													
70. Spastic movements													
71. Do you drop objects often?													
72. Are you accident prone?													
Psychological													
73. Sudden, abrupt mood swings													
74. Unusual depression													
75. Disorientation (getting or feeling lost)													
76. Feeling as if you are losing your mind													
77. Explosive anger													
78. Decreased frustration tolerance													
79. Paranoia													
80. Overemotional reactions / crying easily													
81. Sleeping too much													
82. Difficulty falling or staying asleep													
83. Do you think about suicide?													
84. Do you have homicidal thoughts?													
85. Do you have generalized anxiety?													
86. Have you decreased social functioning?													
87. Has your job/school performance decreased?													
88. Are you obsessive/compulsive?													
Page 3 Subtotal													
Page 2 Subtotal													
Page 1 Subtotal													
Multiply by			5	4	3	2	1						
TOTAL													

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