Integrative Health Center of Maine

Offering the best of conventional and natural healthcare

15 Skyview Drive
Cumberland Foreside, ME 04110

ph: 207.699.3830 f: 207.699.3831
www.maineintegrative.com

Welcome to Integrative Health Center of Maine

- Congratulations -- you are taking an important step in helping yourself achieve a full and healthy life! We look forward to seeing you soon. In the meantime, please review this information packet for some important policies:
- If we have enclosed a Health Appraisal Questionnaire, please be as thorough as you can -- it will help us to understand your health needs more completely.
- Please continue to see you current primary care provider for ongoing health maintenance and screening testing, unless you specify that you want **Dr. Chester** to take over your primary care needs.
- Please bring in any medications and supplements you are currently taking. This will allow **Dr. Chester** to have an accurate list and check for any unhealthy interactions. For instance, some supplement manufacturers do not adhere to strict quality control guidelines. By knowing exactly what you are taking, we can assist you in finding the safest, most effective, and least costly treatments.
- We have enclosed a Release of Information form to send to your provider's office. Note that it takes many providers' offices two to three weeks or more to send medical records to us -- allow plenty of time ahead of your appointment. If you have your own medical records, please bring them to your appointment.
- Some of our practitioners can give you a Superbill to submit to your insurance company for reimbursement. Please let us know if you need a Superbill or if you have any questions about how to submit information for reimbursement. **Dr. Chester** can communicate with your insurance company regarding reimbursement appeals (if you request it), but she may charge for extensive time spent in communication and for chart printing.
- We often have therapy dogs in the office. **If you have a severe allergy to dogs please notify us** ahead of time so we may accommodate you. Similarly, if you are not comfortable being around dogs, please let us know and we would be happy to isolate them during your visit. There is no extra charge for therapy dog services.
- Many of our patients have extreme sensitivities to multiple chemicals. Please do not wear scented products on the day of your visit. Please refrain from smoking 60 minutes prior to your visit.
- If you need to cancel or reschedule your appointment, be sure to do so at least one 24-hour business day prior to your scheduled appointment. **Otherwise you will be responsible for full payment for your appointment.**
- We are a family-friendly office, but we do not have childcare services. If you are bringing children to your appointment, you will be responsible for their care. We strive to maintain a peaceful and nurturing environment -- if you think your children's behavior may be disruptive, please arrange for proper supervision.
- Payment is expected on the day of the appointment. **Dr. Chester** does not participate in any form of private insurance at this time, but will accept Medicare. You must bring your cards at the time of service. We accept cash, check, Visa, Discover, and MasterCard. Most of Dr.Chester's charges are based on the amount of time spent, including face-to-face or phone consultation, email correspondence, or for extensive chart review (>15 minutes). Outstanding unpaid balances will have standard interest rates applied after 30 days, unless otherwise arranged with the practitioner. She is an 'Out-of-Network Provider for private insurance. Check with your insurance company to see if they cover for Out of Network services; you may need to submit a claims form to get reimbursed. Dr. Chester is happy to provide a Superbill that contains the relevant insurance codes for the claims form. If you have secondary insurance besides Medicare, you may still submit to the secondary insurance company for reimbursement for Out of Network provider services. All standard laboratory services, referrals to other In Network providers, etc. should be covered normally under your insurance policy.

Please let us know if you have any questions. For more information please visit our website: www.maineintegrative.com.

We look forward to seeing you soon – thank you and be well!

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Please complete the following information legibly and completely. Thank you!

First name:_____ Last name:_____ Middle int.:_____

Preferred Pronoun (optional): _____

Billing address:_____ DOB:_____

City:_____ State:_____ Zip:_____ Sex:_____

Email Address:_____

Home Phone:_____ Cell Phone:_____

Work Phone:_____ Employer/Occupation:_____

Relationship Status:_____ Partner's Name:_____

Emergency Contact:_____ Phone #:_____

Primary Insurance Name:_____ Group #_____

Address:_____ ID#:_____

City:_____ State:_____ Zip:_____

Name of Guarantor:_____DOB_____

Primary Insurance Phone #:_____

Secondary Insurance Name:_____ Group #:_____

Address:_____ ID #:_____

City:_____ State:_____ Zip:_____

Secondary Insurance Phone#:_____

Preferred Pharmacy: _____ City: _____

Allergies:_____

Medications_____

please see reverse side

Receipt of Notice of Privacy Practices and Practice Policies
Written Acknowledgment Form

I. _____, have been informed about the
Patient/Guardian name

Integrative Health Center of Maine Notice of Privacy Practices and Practice Policies.

_____ _____
Signature of patient/guardian Date

Many of our patients have chemical sensitivities. Please refrain from wearing any scented products including perfumes.

If you smoke, please refrain from smoking at least 60 minutes before entering the office.

_____ _____
Initial of patient/guardian Date

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Advance Beneficiary Notice (ABN)

In plain English: this form says that you are aware that your health insurance company may not pay for our services. Payment is required at the time of visit.

Your health insurance company may not pay for the item(s) or service(s) that are described below. Some health insurance companies including Medicare do not pay for all your health care costs. They only pay for covered items and services when their rules are met. The fact that they may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your health care provider recommends it. Right now, in your case, your health insurance company may not pay for any of the following: Integrative Family Medicine, Intravenous Therapies, Nutriceutical/Supplement/Vitamin therapy, and/or Functional Laboratory Testing because any of these services may be considered "out of network" and/or experimental and/or not FDA-approved.

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully.**

- Ask us to explain if you don't understand why your health insurance company probably won't pay.
- Ask us how much these items or services will cost you (Estimated cost $73 for 15 minutes, discounted for 30 minutes or longer visits) in case you have to pay for them yourself.

I understand that my health insurance company may not pay for these services and that I am responsible for full payment at the time of visit. I have read and agree to the Practice policies in the Welcome letter. I understand that my insurance company will not decide whether to pay unless I receive these items or services. I understand that you may bill me for items or services and that I have to pay the bill while my health insurance company is making its decision. If my health insurance company does pay, they will reimburse me directly any payments I made to you that are due to me. If my health insurance company denies payment, I agree to be personally and fully responsible for payment. I understand I can appeal my health insurance company's decision. I understand I am fully responsible for all communication with my insurance company, and that if I ask IHCM to perform administrative tasks and/or communicate with my insurance company I will be charged for time spent at the usual rates.

NOTE: **Your health information will be kept confidential**. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to your health insurance company, your health information may be shared with your health insurance company. Your health information that your health insurance company sees will be kept confidential by your health insurance company.

A Notice of Privacy Practices document regarding HIPAA policies for confidential and protected healthcare information is available upon request and can be found on our website. By signing below you acknowledge that you have been informed about our Notice of Privacy Practices.

I also attest that I am seeking care only for myself, and that I do not represent a third party.

_____ _____

Signature of patient/guardian Date

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AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, Date of birth ___/___/_____

hereby request and authorize:

_____
(Medical office releasing records)

_____
(Medical office address) (Phone) (Fax)

to release the following medical records and information to the

Integrative Health Center of Maine
15 Sky View Drive, Cumberland Foreside, Maine 04110
Tel: (207) 699.3830 Fax: (207) 699.3831
Provider_____

(Check all that apply) – REQUIRED BY STATE LAW

_____ complete medical records _____ last twelve months only
_____ all laboratory reports _____ last twelve months only

The purpose for releasing this information is:

_____ Further medical care at IHCM _____ Transfer of care

I DO authorize the disclosure of any information relating to the diagnosis or treatment of ALCOHOL or DRUG ABUSE. If I authorize the release of this information, I understand that such information cannot be re-disclosed by a recipient without my specific consent.	I DO NOT. _____ (Initial here).
I DO authorize the disclosure of any information relating to the diagnosis or treatment of MENTAL HEALTH.	I DO NOT. _____ (Initial here).
If I authorize the release of Mental Health, I DO NOT want to review the information before it is released.	I DO: _____ (Initial here). I understand that such review must be supervised.
I DO authorize disclosure of information which refers to HIV test results, infection status or treatment information.	I DO NOT. _____ (Initial here).

This release authorization is valid for six months from date below. It may be revoked sooner by a signed, written revocation, except to the extent that action has already been taken upon this release.

_____
Signature of patient/guardian (indicate relationship to patient) Date

_____
Witness Date

Health Inventory Sheet

(This information is confidential and will only be released with your signed consent)

Name: _____ Birth date: _____
Last First Initial

do not need to duplicate on registration page

Address: _____ Age ____ Sex ____ Height ____ Weight ____

City: _____ State/ZIP _____ Legal Status: S M D Sep W

Phone: W _____ H _____ C _____ Email: _____

Okay to leave a message by phone? Home _____ Cell _____ Work _____ Occupation: _____

If under 18, parent's name/address _____

Emergency Contact: Name _____ Phone _____ Relationship _____

Main Concern(s): _____

_____

_____

FAMILY HISTORY

☐ *Check if family history is unknown*

Relative	Age	If deceased, cause of death
Father		
Mother		
Siblings		

Children	Age	Problems

Check items that apply to blood relatives (children, sisters, brothers, parents, grandparents, aunts, uncles).

YES		RELATIONSHIP
☐	Alcohol/Drug problem	
☐	Allergy/Asthma	
☐	Anemia	
☐	Arthritis	
☐	Binge eating/Bulimia	
☐	Cancer	
☐	Diabetes	
☐	Epilepsy/Seizure	
☐	Gastro Intestinal	
☐	Gonorrhea	
☐	Heart Disease	
☐	High Blood Pressure	

YES		RELATIONSHIP
☐	High Cholesterol	
☐	Hormonal Imbalance	
☐	Kidney/Liver Disease	
☐	Mental Illness	
☐	Obesity	
☐	Skin Disease	
☐	Stroke	
☐	Suicide	
☐	Syphilis	
☐	Thyroid Disease	
☐	Tuberculosis	

Please turn page.

Past History of Illness and Medical Problems

Surgery: List all surgery and approximate dates

Other hospitalizations and dates

Broken bones and/or traumatic injuries
(include all car accidents or concussions/head injuries)

Current health problems
(example: high blood pressure—10yrs)

Past History

YES		WHEN	YES		WHEN	YES		WHEN
☐	Alcohol/Drug problems		☐	Gonorrhea		☐	Respiratory problems	
☐	Allergies/Hay fever		☐	Gout		☐	Rheumatic fever	
☐	Amalgams/silver fillings		☐	Headaches/Migraine		☐	Root canal	
☐	Anemia		☐	Hearing problems		☐	Scarlet fever	
☐	Antibiotics (frequent use)		☐	Heart problems		☐	Seizure/Convulsions	
☐	Anxiety		☐	Hemorrhoids		☐	Sexual dysfunction	
☐	Arthritis		☐	Hepatitis		☐	STDs	
☐	Asthma		☐	Herpes		☐	Sinusitis	
☐	Back pain/strain		☐	Hives		☐	Skin problems	
☐	Bladder infections		☐	High/low blood pressure		☐	Sleep disorder	
☐	Blood clots		☐	High cholesterol		☐	Steroid use	
☐	Bowel problems		☐	HIV/AIDS		☐	Stroke	
☐	Breast lump		☐	Hypoglycemia		☐	Suicide attempt	
☐	Cancer		☐	Insomnia		☐	Syphilis	
☐	Chemical sensitivity		☐	Kidney problems		☐	Thyroid problems	
☐	Chicken pox		☐	Liver disease		☐	Tooth problems	
☐	Chronic fatigue		☐	Measles		☐	Tuberculosis	
☐	Congenital defect		☐	Menstrual problems		☐	Urinary problems	
☐	Dental problems		☐	Mental Illness		☐	Vaginitis	
☐	Depression		☐	Mumps		☐	Vascular problems	
☐	Diabetes		☐	Nervous condition		☐	Vision problems	
☐	Digestive problems		☐	Neurologic problems		☐	Warts	
☐	Eating disorders		☐	Over/under weight		☐	Other problems	
☐	Ear infection		☐	Panic attacks		☐	Were you born vaginally or by C/S?	
☐	Eczema		☐	Peptic ulcer		☐	Were you breastfed as a baby?	
☐	Endometriosis		☐	Phlebitis				
☐	Epilepsy		☐	Pneumonia/Bronchitis				
☐	Eye/vision problems		☐	Premenstrual tension				
☐	Fibroids		☐	Prostate problems				
☐	Gallbladder problems		☐	Reaction to vaccinations				

Review of Systems

Check if you have had these symptoms in the last 6 months

- ☐ Mood swings
- ☐ Trembling episodes
- ☐ Light-headedness
- ☐ Frequent infection
- ☐ Night sweats
- ☐ Swollen glands
- ☐ Skin rash
- ☐ Chills/fever
- ☐ Change in skin/nails
- ☐ Change in wart/mole
- ☐ Abnormal bleeding/bruising
- ☐ Change in hair loss/growth
- ☐ Irritability
- ☐ Restlessness
- ☐ Dizziness
- ☐ Balance problems
- ☐ Poor memory
- ☐ Difficulty concentrating
- ☐ Fainting
- ☐ Weakness
- ☐ Numbness/tingling
- ☐ Excessive tearing/itching
- ☐ Dry mouth
- ☐ Excessive salivation
- ☐ Bleeding gums
- ☐ Bloody/yellow sputum
- ☐ Shortness of breath
- ☐ Pain/discomfort while eating
- ☐ Nausea/vomiting
- ☐ Change in diet

Women

Last menstrual period: _____

Usual length of cycle _____

Usual length of period _____

Age menstruation began _____

Age at menopause _____

Number of pregnancies _____

Number of live births _____

Number of abortions/miscarriages _____

- ☐ Complication of pregnancy ## C/S, forceps delivery
- ☐ Used birth control pills
- ☐ Used IUD; Type: _____
- ☐ Change in cycle
- ☐ Spotting between periods
- ☐ Discomfort with periods
- ☐ Premenstrual tension
- ☐ Vaginal discharge
- ☐ Painful intercourse
- ☐ Itching
- ☐ Self breast examination
- ☐ Problem with sexual function
- ☐ Lump in breast
- ☐ Abnormal pap smear
- ☐ Infertility
- ☐ Did you breastfeed your children? Approx how long?

Date of last pap smear _____

Men

- ☐ Enlarged prostate
- ☐ Decreased urine stream
- ☐ Unable to interrupt stream
- ☐ Dribbling after urination
- ☐ Pus or drainage from penis
- ☐ Genital swelling/rash
- ☐ Problem with sexual function

Do you believe you have had an adverse reaction to a vaccination? If so, please list which vaccination(s) and approximate dates:

_____

_____

_____

Current Medications

List all prescription and non-prescription medications including dosage

_____

_____

_____

_____

_____

_____

Vitamin and Mineral Supplements

Type and dosage

_____

_____

_____

_____

_____

_____

Allergies

I am allergic to the following medications:

_____

_____

_____

_____

_____

_____

Food allergies and method of testing

_____

_____

_____

_____

_____

_____

Please turn page.

Personal History

Lifestyle

List your favorite foods or cravings:

_____

_____

_____

_____

_____

_____

I am now or have been a smoker. ☐Yes ☐No

If yes:

How many years have you smoked? _____

How much? _____

When did you quit? _____

I estimate my use of:

coffee:_____ cups/day decaf:_____ cups/day

I consider myself a ☐non-drinker ☐social drinker ☐heavy drinker ☐alcoholic ☐recovering alcoholic

I use: ☐marijuana ☐other drugs:_____

I have participated in an exercise program. ☐Yes ☐No

I exercise on a regular basis. ☐Yes ☐No

_____times _____week/month

I currently see a chiropractor, osteopath, or other physical therapy practitioner: ☐Yes ☐No

My last physical exam was_____

I find my work ☐too demanding ☐boring ☐satisfactory ☐very satisfactory

Interests/Hobbies

_____

_____

_____

_____

_____

_____

My sex life is satisfactory ☐Yes ☐No

I do the following for relaxation/recreation: _____

_____

_____

My spiritual life is satisfactory. ☐Yes ☐No

I am currently involved in a regular spiritual program: ☐Yes ☐No

I sleep well. ☐Yes ☐No

I worry about: ☐money ☐job ☐family life

☐relationships ☐other_____

I have been a victim of abuse. ☐physical ☐sexual ☐emotional

Are you fearful of: ☐animals ☐people

☐being alone ☐darkness ☐death ☐diseases

☐robbers ☐sudden noises ☐thunder ☐the future

☐high places ☐the unknown ☐other_____

_____

_____

Any additional information about yourself that you feel we have missed:

_____

_____

_____

_____

_____

_____

_____

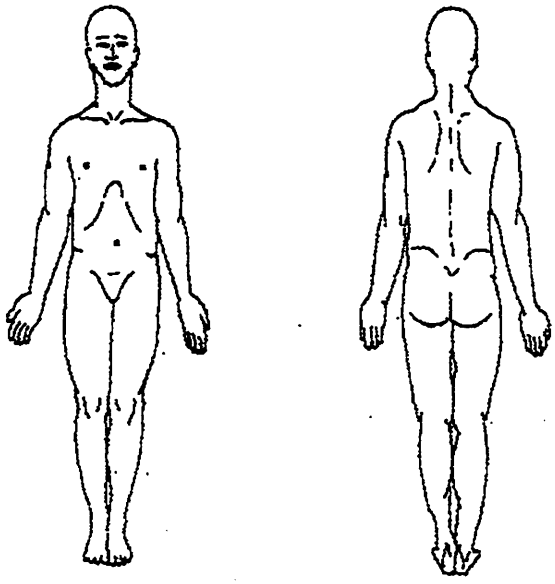
_____

_____

_____

_____

Please mark an "X" to indicate areas where you feel pain, swelling or discomfort, or areas of your skin that have changed color or texture (e.g., moles, rashes, etc.). Describe what you feel or observe in your own words. Write anywhere in this area.



 MET423 11/02

Multiple Systemic Infectious Diseases Syndrome

Six Signs to Watch For:

1. You have more than one symptom

- *Fatigue*
- *Joint and muscle pain*
- *Tingling*
- *Numbness and burning sensations*
- *A stiff neck*
- *Headaches*
- *Light and sound sensitivity*
- *Dizziness*
- *Difficulty falling asleep and staying asleep*
- *Memory and concentration problems*
- *Chest pain with palpitations*
- *Psychiatric symptoms such as depression and anxiety*

2. You have good days and bad days.

A hallmark of Lyme disease is that the symptoms tend to come and go with good and bad days.

3. The pain changes and moves around the body

[illegible] of Lyme disease is the migratory nature of the [illegible] joint pain as well as the tingling, numbness and [illegible] often tend to come and go and move around the body. One day the joint pain might be in the knees, [illegible] in the shoulders, and two days later it's in the [illegible] symptoms can happen with Lyme neuropathy, [illegible] have affected the nerves, and the tingling, numbness, burning sensations migrate to different areas around the body.

4. If you're a woman, your symptoms worsen right around your cycle.

Women will often have a worsening of Lyme symptoms right before, during, or after their menstrual cycle. Lyme disease symptoms are known to change with fluctuating levels of estrogen and progesterone.

5. Your symptoms improve when you're taking medication for other ailments.

Patients taking antibiotics for an unrelated problem (such as upper respiratory infection or urinary tract infection), will often report that their symptoms are much better while taking the antibiotic, and worsen when the antibiotic is stopped. Conversely, some individuals feel much worse on antibiotics, where all of their symptoms are intensified. This is called a Jarish-Herxheimer reaction, where the Lyme bacteria are being killed off and temporarily worsen the underlying symptoms.

6. Blood tests have confirmed this.

The sixth and final point to determine if your symptoms are due to Lyme disease is to ask your health care provider to run a blood test called a Western Blot through a reliable laboratory, like IgeneX labs in [illegible]. There are over 100 different strains of Lyme disease in the [illegible] worldwide, and IgeneX uses several strains to [illegible] testing.

Although there are several different laboratory tests to diagnose Lyme disease, [illegible] ELISA test, Western Blot, PCR (DNA) test or occa[illegible] tests each have their pros and cons, and can [illegible] diagnosis because they are not sensitive enough [illegible] presence of the bacteria.

[illegible] bands (proteins) on the Western Blot that are [illegible] to Lyme. These proteins (bands) are the 23, 31, [illegible] and 83-93 kDA bands. Any one of these bands on a Western blot with the above symptoms mentioned (having been properly ruled out for other diseases) is pathognomonic for Lyme disease.

A bullseye rash is also a classic manifestation of Lyme disease, and does not require a positive blood test, but less than 50% of people may get the rash, and it may be located in a part of the body where the rash cannot easily be seen.

Disclaimer: The Horowitz Lyme-MSIDS Questionnaire is not intended to replace the advice of your own physician or other medical professional. You should consult a medical professional in matters relating to health, and individuals are solely responsible for their own health care decisions regarding the use of this questionnaire. It is intended for informational purposes only and not for self-treatment or diagnosis.

[illegible] www.[illegible].com

MSIDS

Multiple Systemic Infectious Diseases Syndrome

MSIDS is a symptom complex of Lyme disease and multiple associated tick borne co-infections that encompasses not only infections with *Borrelia burgdorferi*, the etiological agent of Lyme Disease, but also other bacterial infections, viral infections, parasitic infections, and fungal infections."

Why Can't I Get Better? *by Richard I. Horowitz, M.D.*

MSIDS Symptoms Can Include:

- Abnormal liver functions
- Allergies
- Autonomic nervous system dysfunction
- Endocrine abnormalities
- Environmental toxicity
- Enzyme deficiencies
- Functional medicine abnormalities in biochemical pathways
- Gastrointestinal abnormalities
- Immune dysfunction
- Inflammation
- Mitochondrial dysfunction
- Neuropsychological issues
- Nutritional deficiencies
- POTS
- Pain issues
- Physical de-conditioning
- Sleep disorders
- Day sweats, night sweats, chills
- Shortness of breath with unexplained cough, possibly from babesiosis, a malaria type parasite contracted through tick bites

"The ILADS guidelines stress the importance of a doctor's clinical judgment in making the diagnosis, because the scientific literature has found that the existing testing is unreliable. The IDSA narrowly restricts the diagnosis to include the CDC criteria. However, many doctors in the United States do not follow IDSA guidelines. Instead, my model allows Lyme to be redefined as MSIDS: a clinical syndrome that encompasses multiple overlapping factors that keep patients chronically ill." *Richard Horowitz, MD*

INSIDE: *A questionnaire to help determine the probability of your having MSIDS, Lyme disease, and/or other tick borne illnesses.*

All information contained in this brochure is drawn from ***"Why Can't I Get Better?"*** *by Richard Horowitz, MD. Dr. Horowitz is an internationally respected expert on Lyme and other tick borne diseases.*

[illegible] www.[illegible].com

SECTION 1: SYMPTOM FREQUENCY SCORE

0 = None 1 = Mild 2 = Moderate 3 = Severe

Write in a 0,1,2 , or 3 on the line to the right of the symptom

1	Unexplained fevers, sweats, chills, or flushing	____
2	Unexplained weight change; loss or gain	____
3	Fatigue, tiredness	____
4	Unexplained hair loss	____
5	Swollen glands	____
6	Sore throat	____
7	Testicular or pelvic pain	____
8	Unexplained menstrual irregularity	____
9	Unexplained breast milk production; breast pain	____
10	Irritable bladder or bladder dysfunction	____
11	Sexual dysfunction or loss of libido	____
12	Upset stomach	____
13	Change in bowel function (constipation or diarrhea)	____
14	Chest pain or rib soreness	____
15	Shortness of breath or cough	____
16	Heart palpitations, pulse skips, heart block	____
17	History of a heart murmur or valve prolapse	____
18	Joint pain or swelling	____
19	Stiffness of the neck or back	____
20	Muscle pain or cramps	____
21	Twitching of the face or other muscles	____
22	Headaches	____
23	Neck cracks or neck stiffness	____
24	Tingling, numbness, burning, or stabbing sensations	____
25	Facial paralysis (Bell's palsy)	____
26	Eyes/vision: double, blurry	____
27	Ears/hearing: buzzing, ringing, ear pain	____
28	Increased motion sickness, vertigo	____
29	Light-headedness, poor balance, difficulty walking	____
30	Tremors	____
31	Confusion, difficulty thinking	____
32	Difficulty with concentration or reading	____
33	Forgetfulness, poor short-term memory	____
34	Disorientation: getting lost; going to wrong places	____
35	Difficulty with speech or writing	____
36	Mood swings, irritability, depression	____
37	Disturbed sleep: too much, too little, early awakening	____
38	Exaggerated symptoms or worse hangover from alcohol	____

Total Section 1 ..... ☐

SECTION 2: MOST COMMON LYME SYMPTOMS SCORE

If you rated a "3" in Section 1 for <u>each of the following</u> symptoms, give yourself 5 additional points:

- Fatigue
- Forgetfulness, poor short-term memory
- Joint pain or swelling
- Tingling, numbness, burning, or stabbing sensations
- Disturbed sleep: too much, too little, early awakening

<u>Total Section 2</u> *<u>(enter either "5" or "0")</u>* ..... ☐

SECTION 3: LYME INCIDENCE SCORE

Now apply the points for each of the following statements you can agree with:

1	You have had a tick bite with no rash or flulike symptoms. ***3 points***	____
2	You have had a tick bite, an erythema migrans, or an undefined rash, followed by flulike symptoms. ***5 points***	____
3	You live in what is considered a Lyme-endemic area. ***2 points***	____
4	You have a family member who has been diagnosed with Lyme and/or other tick-borne infections. ***1 point***	____
5	You experience migratory muscle pain. ***4 points***	____
6	You experience migratory joint pain. ***4 points***	____
7	You experience tingling/burning/numbness that migrates and/or comes and goes. ***4 points***	____
8	You have received a prior diagnosis of chronic fatigue syndrome or fibromyalgia. ***3 points***	____
9	You have received a prior diagnosis of a specific autoimmune disorder (lupus, MS, or rheumatoid arthritis), or of a nonspecific autoimmune disorder. ***3 points***	____
10	You have had a positive Lyme test (IFA, ELISA, Western blot, PCR, and/or borrelia culture). ***5 points***	

Total - Section 3 ..... ☐

SECTION 4: OVERALL HEALTH SCORE

1 Thinking about your overall physical health, for how many of the past thirty days was your physical health not good?
_____ days

Award yourself the following points based on the total number of days: ☐

0 – 5 days = 1 point
6 – 12 days = 2 points
13 – 20 days = 3 points
21 – 30 days = 4 points

2 Thinking about your overall mental health, for how many days during the past thirty days was your mental health not good? _____ days

Award yourself the following points based on the total number of days: ☐

0 – 5 days = 1 point
6 – 12 days = 2 points
13 – 20 days = 3 points
21 – 30 days = 4 points

Total Section 4 ..... ☐

Record your total scores for each section and add them together to achieve your final score ..... ☐

If you scored 46 or more, you have a high probability of a tick-borne disorder and should see a health-care provider for further evaluation.

If you scored between 21 and 45, you possibly have a tick-borne disorder and should see a health-care provider for further evaluation.

If you scored under 21, you are not likely to have a tick-borne disorder.

Review of Systems

Check if you have had these symptoms in the last 6 months

- ☐ Mood swings
- ☐ Trembling episodes
- ☐ Light-headedness
- ☐ Frequent infection
- ☐ Night sweats
- ☐ Swollen glands
- ☐ Skin rash
- ☐ Chills/fever
- ☐ Change in skin/nails
- ☐ Change in wart/mole
- ☐ Abnormal bleeding/bruising
- ☐ Change in hair loss/growth
- ☐ Irritability
- ☐ Restlessness
- ☐ Dizziness
- ☐ Balance problems
- ☐ Poor memory
- ☐ Difficulty concentrating
- ☐ Fainting
- ☐ Weakness
- ☐ Numbness/tingling
- ☐ Excessive tearing/itching
- ☐ Dry mouth
- ☐ Excessive salivation
- ☐ Bleeding gums
- ☐ Bloody/yellow sputum
- ☐ Shortness of breath
- ☐ Pain/discomfort while eating
- ☐ Nausea/vomiting
- ☐ Change in diet

Women

Last menstrual period: _____

Usual length of cycle _____

Usual length of period _____

Age menstruation began _____

Age at menopause _____

Number of pregnancies _____

Number of live births _____

Number of abortions/miscarriages _____

- ☐ Complication of pregnancy th C/S, forceps delivery
- ☐ Used birth control pills
- ☐ Used IUD; Type: _____
- ☐ Change in cycle
- ☐ Spotting between periods
- ☐ Discomfort with periods
- ☐ Premenstrual tension
- ☐ Vaginal discharge
- ☐ Painful intercourse
- ☐ Itching
- ☐ Self breast examination
- ☐ Problem with sexual function
- ☐ Lump in breast
- ☐ Abnormal pap smear
- ☐ Infertility
- ☐ Did yai breastfeed your children? Approx how long?

Date of last pap smear _____

Men

- ☐ Enlarged prostate
- ☐ Decreased urine stream
- ☐ Unable to interrupt stream
- ☐ Dribbling after urination
- ☐ Pus or drainage from penis
- ☐ Genital swelling/rash
- ☐ Problem with sexual function

Do you believe you have had an adverse reaction to a vaccination? If so, please list which vaccination(s) and approximate dates:

_____

_____

_____

Current Medications

List all prescription and non-prescription medications including dosage

_____

_____

_____

_____

_____

_____

Vitamin and Mineral Supplements

Type and dosage

_____

_____

_____

_____

_____

_____

Allergies

I am allergic to the following medications:

_____

_____

_____

_____

_____

_____

Food allergies and method of testing

_____

_____

_____

_____

_____

_____

Please turn page.

Personal History

Lifestyle

List your favorite foods or cravings:

_____
_____
_____
_____
_____
_____

I am now or have been a smoker. ☐Yes ☐No
If yes:
How many years have you smoked? _____
How much? _____
When did you quit? _____

I estimate my use of:
coffee:_____ cups/day decaf:_____ cups/day

I consider myself a ☐non-drinker ☐social drinker
☐heavy drinker ☐alcoholic ☐recovering alcoholic

I use: ☐marijuana ☐other drugs:_____

I have participated in an exercise program. ☐Yes ☐No

I exercise on a regular basis. ☐Yes ☐No
_____times _____week/month

I currently see a chiropractor, osteopath, or other physical therapy practitioner: ☐Yes ☐No

My last physical exam was_____

I find my work ☐too demanding ☐boring
☐satisfactory ☐very satisfactory

Interests/Hobbies

_____
_____
_____
_____
_____
_____

My sex life is satisfactory ☐Yes ☐No

I do the following for relaxation/recreation: _____
_____
_____

My spiritual life is satisfactory. ☐Yes ☐No

I am currently involved in a regular spiritual program: ☐Yes ☐No

I sleep well. ☐Yes ☐No

I worry about: ☐money ☐job ☐family life
☐relationships ☐other_____

I have been a victim of abuse. ☐physical ☐sexual
☐emotional

Are you fearful of: ☐animals ☐people
☐being alone ☐darkness ☐death ☐diseases
☐robbers ☐sudden noises ☐thunder ☐the future
☐high places ☐the unknown ☐other_____
_____
_____

Any additional information about yourself that you feel we have missed:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____