



CAROLINACENTER
FOR INTEGRATIVE MEDICINE

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**MULTI-SYSTEMIC INFECTIOUS DISEASE SYNDROME
SYMPTOM QUESTIONNAIRE**

SECTION 1: SYMPTOM FREQUENCY SCORE

Select the frequency of each of the following symptoms.
0 = None 1 = Mild 2 = Moderate 3 = Severe

1. ___ Unexplained fever, 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 stiffness
24. ___ Tingling, numbness, burning, or stabbing sensations
25. ___ Facial paralysis (Bell's palsy)
26. ___ Eye/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



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- 35. ___ Difficulty with speech or writing
- 36. ___ Mood swings, irritability, depression
- 37. ___ Disturbed sleep: too much, too little, early awakening
- 38. ___ Exaggerated symptoms of worse hangover from alcohol

TOTAL SCORE FOR THIS SECTION: _____

SECTION 2: MOST COMMON LYME SYMPTOMS SCORE

If you rated a 3 for each of the following symptoms in section 1, give yourself 5 points for each of these symptoms. Circle 0 if you didn't rate a 3.

- 39. 0 or 5 Fatigue
- 40. 0 or 5 Forgetfulness, poor short-term memory
- 41. 0 or 5 Joint pain or swelling
- 42. 0 or 5 Tingling, numbness, burning, or stabbing sensations
- 43. 0 or 5 Disturbed sleep: too much, too little, early awakening

TOTAL SCORE FOR THIS SECTION: _____

SECTION 3: LYME INCIDENCE SCORE

Now for each of the following statements that is true, circle 3

- 44. 0 or 3 You have had a tick bite with no rash or flulike symptoms.
- 45. 0 or 3 You have had a tick bite, an erythema migrans, or an undefined rash, followed by flulike symptoms.
- 46. 0 or 3 You live in what is considered a Lyme-endemic area.
- 47. 0 or 3 You have a family member who has been diagnosed with Lyme and/or other tick-borne infections.
- 48. 0 or 5 You experience migratory muscle pain.
- 49. 0 or 5 You experience migratory joint pain.
- 50. 0 or 5 You experience tingling/burning/numbness that migrates and/or comes and goes.
- 51. 0 or 5 You have received a prior diagnosis of chronic fatigue syndrome or fibromyalgia.
- 52. 0 or 5 You have received a prior diagnosis of a specific autoimmune disorder (lupus, MS, or rheumatoid arthritis) or of a nonspecific autoimmune disorder.
- 53. 0 or 5 You have had a positive Lyme test (IFA, ELISA, Western blot, PCR, and/or Borrelia culture).

TOTAL SCORE FOR THIS SECTION: _____



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SECTION 4: OVERALL HEALTH SCORE

54. Thinking about your overall physical health, for how many of the past 30 days was your physical health not good? Award yourself the following points based on the total number of days.

- 0 to 5 days - 1
- 6 to 12 days - 2
- 13-20 days - 3
- 21 to 30 days - 4

55. Thinking about your overall mental health, for how many of the past 30 days was your mental health not good? Award yourself the following points based on the total number of days.

- 0 to 5 days - 1
- 6 to 12 days - 2
- 13-20 days - 3
- 21 to 30 days - 4

TOTAL SCORE FOR THIS SECTION: _____

TOTALS:

- Section 1: _____
- Section 2: _____
- Section 3: _____
- Section 4: _____

FINAL TOTAL SCORE: _____

INTERPRETATION:

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

If you scored between 21 and 45, you possibly have a tick-borne disorder

If you scored 46 or more, you have a high probability of a tick-borne disorder



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MULTI-CHRONIC INFECTIOUS DISEASE SYNDROME POTENTIAL PATIENT QUESTIONNAIRE

Name: _____ Date: _____ Age: _____

1. Where do you live? City: _____ State: _____
2. How long have you been sick? (circle) <1 yr 1-2 yrs 3-5 yrs 6-10 yrs >10 yrs (___)
 - a. Have you been continuously ill (_____) or have had periods of recovery and relapse? (____) (check whichever applies)
 - b. Rate your overall health status including level of pain, fatigue, neurologic or other symptoms by circling the number that applies:
(severely ill) 1 2 3 4 5 6 7 8 9 10 (healthy)
3. What is your status (check one)
 - a. ____ Working full time at an office
 - b. ____ Working part time at an office
 - c. ____ Working full time at home
 - d. ____ Working part time at home
 - e. ____ Not working due to health problems
 - f. ____ Not working for other reasons
 - g. ____ Have you been declared disabled and are receiving any disability services (insurance, financial support, etc.)
4. What infections have you been either diagnosed with or are suspected based on clinical symptoms? Check all that apply:
 - a. ____ Borrelia (Lyme Disease)
 - b. ____ Bartonella
 - c. ____ Babesia - any specific species? _____
 - d. ____ Other bacteria? _____
 - e. ____ Mycoplasma
 - f. ____ Viruses - any specific species? _____
 - g. ____ Parasites - any specific species? _____
 - h. ____ Fungi and Yeast (Candida and other species)
 - i. ____ Other _____



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- 5. Have you ever been on any antibiotics? Check which applies:
a. Currently taking antibiotics for the first time (check one below)
i. Taking only oral antibiotics
ii. Taking IV and oral antibiotics
b. Have taken antibiotics in the past and am not on them now
c. Have taken antibiotics, stopped for a while, then resumed and am on them now
d. What is the total time you have been on antibiotics?
e. Did you receive any IV antibiotics? Yes No
f. If so, how long?
g. Did you feel you got any benefit from taking antibiotics? Circle the number that applies: (no benefit) 1 2 3 4 5 6 7 8 9 10 (great benefit)
6. Have you ever used any non-antibiotic therapies to treat your condition? Yes No
a. If so, what have you used? (check all that apply)
i. Herbals
ii. Homeopathic
iii. Detoxification Therapies (colon therapy, chelation, glutathione, fasting)
iv. Hyperbaric Oxygen
v. High Dose IV Vitamin C
vi. Other:
b. Do you feel that any of these therapies were helping? Circle the number that applies:
c. Did you feel you got any benefit from taking antibiotics? Circle the number that applies: (no benefit) 1 2 3 4 5 6 7 8 9 10 (great benefit)
7. Are you on any pain medications? Yes No
a. If so, which ones?
i.
ii.
iii.
iv.
b. How long have you been on pain medications?
8. Have you ever had any lab tests that have shown any liver problems (elevated liver enzymes) Yes No
a. If so, how long did this last?
b. Did it resolve? Yes No When if it has?



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9. Check any secondary problems that you are experiencing beyond the typical tick-borne infection symptoms:
- _____ Women's hormonal issues (PMS, cramping, exaggerated peri-menopausal sx)
 - _____ Neuropathy (numbness and tingling in your extremities)
 - _____ Digestive problems – indigestion, heartburn, gas, bloating, abnormal BM's, etc.
 - _____ Changes in vision or hearing
 - _____ Yeast overgrowth (rectal itching, carbo craving, nail fungus, jock itch, discharge)
10. Check whichever applies regarding dental amalgam fillings:
- _____ I have never had any amalgam fillings.
 - _____ I currently have amalgam fillings. Number: _____
 - _____ I used to have amalgam fillings and have had them replaced with non-toxic materials or crowns.
 - If you have had your amalgams replaced, check the type of dentist who did it:
 - _____ A Biological Dentist who uses protective equipment to prevent mercury from entering the body during the procedure.
 - Did you find this dentist through the IAOMT (International Association of Oral Medicine and Toxicology) Yes No
 - _____ My family dentist who did not use any protective equipment that I was aware of.
 - Did you experience any adverse effects from the removal of your amalgam fillings? (circle) Yes No
 - If so, describe: _____