Summerlin Functional Medicine

Greetings! Step one of scheduling your Functional Medicine appointment is to complete the below paperwork. In order to provide you the very best care, it's extremely thorough. So please allow yourself plenty of time. Completed paperwork can be submitted via email to: office@summerlinfm.com.

PATIENT INFORMATION

Full Legal Name _____ Today's Date _____ Date of Birth _____ Birthplace _____

Preferred Phone Number _____ Secondary Phone Number _____ Email Address _____

Address _____ City _____ State _____ Zip _____ Home _____

Occupation _____ Social Security # _____ Sex _____ Height _____ Weight _____

How old would you be if you didn't know how old you were? _____

How did you hear about us? _____

If you were referred to our office, who referred you? _____

Spouse/Partner Name _____ Marital Status _____ Date of Birth _____ Occupation _____ Phone Number _____

Emergency Contact _____ Relationship _____ Preferred Phone Number _____ Secondary Phone Number _____

INSURANCE INFORMATION

Primary Insurance _____ Policy # _____ Group # _____ Policy Holder Name _____ Relationship to Patient _____

Secondary Insurance _____ Policy # _____ Group # _____ Policy Holder Name _____ Relationship to Patient _____

I hereby declare that the above information is complete and correct to the best of my knowledge, and I authorize the release of information necessary to file a claim with my insurance company. I assign benefits otherwise payable to me, to the doctor, or group indicated on the claim. I understand that I am financially responsible for all charges for medical services rendered regardless of insurance coverage.

Patient Signature: _____ Date:_____

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MEDICAL SYMPTOMS QUESTIONNAIRE

Rate each of the following symptoms based upon your typical health profile over the past 30 days. Please read the following key closely.

0 | never or almost never have the symptom
1 | occasionally have it, effect is not severe
2 | occasionally have it, effect is *severe*
3 | *frequently* have it, effect is not severe
4 | *frequently* have it, effect is *severe*

HEAD
___ Headaches
___ Faintness
___ Dizziness
___ Insomnia

EYES
___ Watery or itchy eyes
___ Swollen, reddened or sticky eyelids
___ Bags or dark circles under eyes
___ Blurred or tunnel vision (not near & farsightedness)

EARS
___ Itchy ears
___ Earaches, ear infections
___ Drainage from ear
___ Ringing in ears, hearing loss

NOSE
___ Stuffy nose
___ Sinus problems
___ Hay fever
___ Sneezing attacks
___ Excessive mucus formation

MOUTH & THROAT
___ Chronic coughing
___ Gagging, frequent need to clear throat
___ Sore throat, hoarseness, loss of voice
___ Swollen or discolored tongue, gums or lips

SKIN
___ Acne
___ Hives, rashes or dry skin
___ Hair loss
___ Flushing, hot flashes
___ Excessive sweating

HEART
___ Irregular or skipped heartbeat
___ Rapid or pounding heartbeat
___ Chest pain

LUNGS
___ Chest congestion
___ Asthma, bronchitis
___ Shortness of breath
___Difficulty breathing

Total_____

DIGESTIVE TRACT
___ Nausea, vomiting
___ Diarrhea
___ Constipation
___ Bloating
___Belching, passing gas
___ Heartburn
___ Intestinal or stomach pain

JOINTS & MUSCLES
___ Pain or aches in joints
___ Arthritis
___ Stiffness or limitation of movement
___ Pain or aches in muscles
___ Weakness or tiredness

WEIGHT
___ Binge eating or drinking
___Craving certain foods
___ Excessive weight
___ Compulsive eating
___ Water retention
___ Underweight

ENERGY & ACTIVITY
___ Fatigue, sluggishness
___ Apathy, lethargy
___ Hyperactivity
___ Restlessness

MIND
___ Poor memory
___ Confusion, poor comprehension
___ Poor concentration
___ Poor physical coordination
___ Difficulty making decisions
___ Stuttering or stammering
___ Slurred speech
___ Learning disabilities

EMOTIONS
___ Mood swings
___ Anxiety, fear or nervousness
___ Anger, irritability or aggressiveness
___ Depression

OTHER
___ Frequent illness
___ Frequent or urgent urination
___ Genital itch or discharge

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PRESENT PHYSICIANS & CONCURRENT MEDICAL CARE

Please list each problem/diagnosis you are currently undergoing treatment for, and the physical or mental healthcare practitioner(s) who are treating you.

Primary Care Physician _____ **Problems/Diagnosis** _____

Other Physician(s) _____ **Problems/Diagnosis** _____

Dr.Bowman is not a primary care physician. Your PCP is responsible for keeping you up to date on CDC & FDA recommendations for health screenings & vaccinations. Dr.Bowman does not keep up with these recommendations.

PLEASE LIST IN ORDER OF IMPORTANCE; problems, symptoms, concerns & goals that you would like to address during your care with us:

1| _____

2| _____

3| _____

4| _____

5| _____

6| _____

7| _____

8| _____

9| _____

10| _____

What is your chief complaint? _____
When did the problem begin?_____

PLEASE LIST all current medications & supplements, prescription and non. Including any estrogen, progesterone, DHEA, testosterone, growth hormone, steroid(s)

NAME	DOSAGE	FREQUENCY	REASON FOR TAKING

PLEASE LIST all allergies to medications & supplements (including what type of reaction you experience and the last time it occurred)

_____

_____

_____

_____

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PAST MEDICAL HISTORY

For each chronic and/or serious medical problem that you have, or have had in the past, please indicate on the line provided YOUR AGE when it occurred, or began.

_____ Cancer (include type)
_____ Fibromyalgia
_____ Chronic Fatigue

INFECTIONS
_____ Tuberculosis
_____ HIV
_____ Mononucleosis/EBV
_____Covid-19
_____ Lyme Disease
_____ Bartonella
_____ Babesia
_____ Mycoplasma

AUTOIMMUNE
_____ Hyperthyroidism
_____ Hypothyroidism
_____ Diabetes Mellitus Type 1
_____ Lupus
_____ Rheumatoid Arthritis
_____ Sjogren's Syndrome
_____ Psoriasis

METABOLIC
_____ Obesity
_____ Hypoglycemia
_____ Prediabetes
_____ High Cholesterol
_____ High Triglycerides
_____Type 2 Diabetes

HEAD
_____ Concussion(s)
_____ Headache/Migraine

NEURODEGENERATIVE
_____ ALS
_____ Alzheimer's
_____ Dementia
_____ Lewy Body Dementia
_____ Parkinson's

EYES
_____ Macular Degeneration
_____ Cataracts
_____ Glaucoma

ENT
_____ Hearing loss
_____ Vertigo

MOUTH
_____ Periodontitis
_____ Root Canal(s)
_____ Tooth Implants(s)

LUNGS
_____ Asthma
_____ Chronic Bronchitis
_____ Emphysema
_____ COPD

CARDIOVASCULAR
_____ Pulmonary Embolism
_____ TIA's
_____ Stroke
_____ Hypertension
_____ Heart Disease
_____ Heart Attack
_____ Phlebitis (blood clot in legs)
_____ Claudication

GASTROINTESTINAL
_____GERD
_____ Barrett's Esophagus
_____ Ulcer(s)
_____ Irritable Bowel Syndrome
_____ SIBO
_____ Pancreatitis
_____ Diverticulitis
_____ Hemorrhoid(s)

LIVER
_____ Fatty Liver
_____ Hepatitis
_____ Cirrhosis

MUSCULOSKELETAL
_____ Osteoporosis
_____ Osteoarthritis
_____ Low Back Pain
_____ Serious Orthopedic Issue(s)

MOOD
_____ Depression
_____ Anxiety
_____ Bipolar
_____ ADHD
_____ Autism Spectrum

WEIGHT
What is your max lifetime weight?____
Current weight? _____
Unexplained weight gain/loss in recent months? **YES** | **NO**

MEN ONLY
_____ Enlarged Prostate
_____ Erectile Dysfunction
_____ Low Testosterone
_____ Elevated PSA
Have you seen a Urologist? **YES** | **NO**
If yes, when?
_____
_____ Last rectal exam
_____ Taken anabolic steroids
_____ Taken prescription testosterone

WOMEN ONLY
_____ Fibrocystic Breasts
_____ Breast Implants
_____ Change in breast size
_____ Self Breast Exams?
_____ PID
_____ PCOS
_____ Endometriosis
_____ Menopause
_____ Nipple Discharge
_____ Birth Control
_____ Age & year periods began
_____ Last pelvic/gynecological exam & result
_____ Number of pregnancies
_____ Age during pregnancies
_____ # of live births
_____ # of miscarriages
_____ # of stillbirths
_____ # of premature births
_____ # of C section births
_____ # of abortions
Did you breastfeed? **YES** **NO**
If yes, how long?
_____

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FAMILY, SURGICAL & SOCIAL HISTORY

CIRCLE ALL THAT APPLY

MOTHER alive & well | deceased | health
issues:_____

FATHER alive & well | deceased | health
issues:_____

PATERNAL GM alive & well | deceased | health
issues:_____

PATERNAL GF alive & well | deceased | health
issues:_____

MATERNAL GM alive & well | deceased | health
issues:_____

MATERNAL GF alive & well | deceased | health
issues:_____

SIBLING alive & well | deceased | health
issues:_____

SIBLING alive & well | deceased | health
issues:_____

SIBLING alive & well | deceased | health
issues:_____

HABITS

Have you used tobacco in the past 30 days? **YES** | **NO** | **SOCIALLY** If yes, what? _____

Have you ever smoked cigarettes? **YES** | **NO** | **SOCIALLY** | **FORMER SMOKER**
How old were you when you started? _____ How many packs do you smoke per day?_____
How many packs maximum did you smoke per day? _____ When did you stop smoking?_____

Have you vaped in the past 30 days? **YES** | **NO** | **SOCIALLY**
How old were you when you started? _____ How old were you when you quit? _____

How many alcoholic drinks do you have in a typical week? **LESS THAN 1** | **NEVER** | **SOCIALLY** **or # per week**_____

How often do you use THC in a typical week? **LESS THAN 1** | **NEVER** | **SOCIALLY** **or # per week**_____

Have you ever had any of the following psychedelic drugs? **LSD** | **PSILOCYBIN/MUSHROOMS** | **OTHER**_____

Do you lose more money gambling than you should? **YES** | **NO** | **I DON'T GAMBLE**
How many times have you gambled in the past 30 days? _____

Please circle all that apply to you: **INSOMNIA** | **TIRED WHEN WAKING UP** | **CAN'T FALL ASLEEP** | **CAN'T STAY ASLEEP** | **SNORING** | **USING SLEEP AIDS** How many hours of sleep do you average per night? _____

Do you have a routine exercise program? **YES** | **NO** if yes, please describe:
_____
What (if anything) physically limits your ability to exercise? _____

Are you currently seeing a mental health professional? **YES** | **NO** if yes, please describe:_____
Have you undergone an inpatient or outpatient medical recovery program? **YES** | **NO**
if yes, please describe: _____

What habits & behaviors do you wish you could stop, but you find it difficult or impossible to do so?
_____

Do you crave any of the following foods? **SUGAR** | **BREAD** | **PASTA** | **ASPARTAME** | **CAFFEINE** | **CHOCOLATE** | **OTHER:**
_____

Please describe your current diet & any you have tried in the past_____
Did any diets make you feel better, or worse? **YES** | **NO** if yes, please describe:_____

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TRAUMA

Have you experienced significant emotional trauma? **YES** | **NO** If yes, please describe:_____
Have you ever been hospitalized as a result of trauma? **YES** | **NO**

PLEASE LIST all times you have been hospitalized due to **medical illness**, elective & nonelective **surgeries**, and **physical trauma or violence**

DATE	DIAGNOSIS	CAUSE	SURGERY	LOCATION/HOSPITAL

ACE QUIZ

Adverse childhood experiences. Circle yes or no. At the end of the quiz, add your score. Each YES = 1.
Prior to your 18th birthday:

1) Did a parent/other adult in your household often: Swear at you, insult you, put you down, humiliate you, or act in a way that made you afraid that you might be physically hurt?
YES | **NO**

2) Did a parent/other adult in your household often: Push, grab, slap, throw something at you, or hit you so hard that you had marks or were injured?
YES | **NO**

3) Did a parent/other adult (at least 5 years older than you) ever: Fondle or touch you, or ask you to touch them in a sexual way? Or actually attempt to have oral, anal, or vaginal intercourse with you?
YES | **NO**

4) Did you often feel that: No one in your family loved you, or though you were important or special? Or your family didn't look out for each other, feel close to, or support each other?
YES | **NO**

5) Did you often feel that: You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? Or your parents were too drunk or high to take care of you, or take you to the doctor if you needed it?
YES | **NO**

6) Were your parents ever separated or divorced?
YES | **NO**

7) Was your mother or stepmother very often: Pushed, grabbed, slapped, or had something thrown at her? Was she ever hit with a fist or something hard, kicked, bitten, hit repeatedly or threatened with a gun or knife?
YES | **NO**

8) Did you live with anyone who was a problem drinker, alcoholic, or street drug user?
YES | **NO**

9) Was a household member depressed, mentally ill, or attempt suicide?
YES | **NO**

10) Did a household member go to prison?
YES | **NO**

This is your ACE score:_____

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STRESS

Do you have an excess amount of stress in your life? **YES | NO**

Rate your stress level while at work: **1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10**

Rate your stress level while at home: **1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10**

Which of the following do you routinely do to help cope with stress? **EXERCISE | PRAYER | MEDITATION | NOTHING | OTHER:**

Do you have a regular & routine religious or spiritual practice? **YES | NO**

Are you able to use your mind without using your brain? **YES | NO | WHAT???**

STRESS RATING SCALE

On the line provided, please note the age at which you experienced each stressor.

_____ Death of spouse (100)
_____ Divorce (73)
_____ Marital separation from mate (65)
_____ Incarceration (63)
_____ Death of close family member (63)
_____ Personal injury or illness (53)
_____ Marriage (50)
_____ Fired from job (47)
_____ Marital or similar reconciliation (45)
_____ Retirement (45)
_____ Major change in health or behavior of family member (44)
_____ Pregnancy (40)
_____ Sex difficulties (39)
_____ Addition to family (39)
_____ Major business readjustment (39)
_____ Major change in financial state (38)
_____ Death of close friend (37)
_____Change to different type of work (36)
_____ Major change in number of arguments with spouse (more or less than usual) (35)
_____ Taking on a mortgage, home or business (31)
_____ Foreclosure of mortgage or loan (30)
_____ Change in responsibility at work (29)
_____ Son or daughter leaving home (29)
_____ Trouble with in laws (29)
_____ Outstanding personal achievement (28)
_____ Spouse began new work, or began working at home (26)
_____ Beginning or ceasing formal schooling (26)
_____ Major change in living conditions (25)
_____ Revision of personal habits (dress, manners, associations, quitting smoking) (24)
_____ Trouble with boss (23)
_____ Major change in work hours or conditions (20)
_____ Change in resilience (20)
_____ Change in schools (20)
_____ Major change in recreation (19)
_____ Major change in religious activities (19)
_____ Major change in social activities (18)
_____ Taking on a loan (17)
_____ Major change in sleeping habits (16)
_____ Major change in number of family gatherings (15)
_____ Major change in eating habits (15)
_____ Vacation (13)
_____ Major holidays (12)
_____ Minor violations of the law (traffic tickets) (11)
_____ Other _____
_____ Other _____
_____ Other _____

Total: _____

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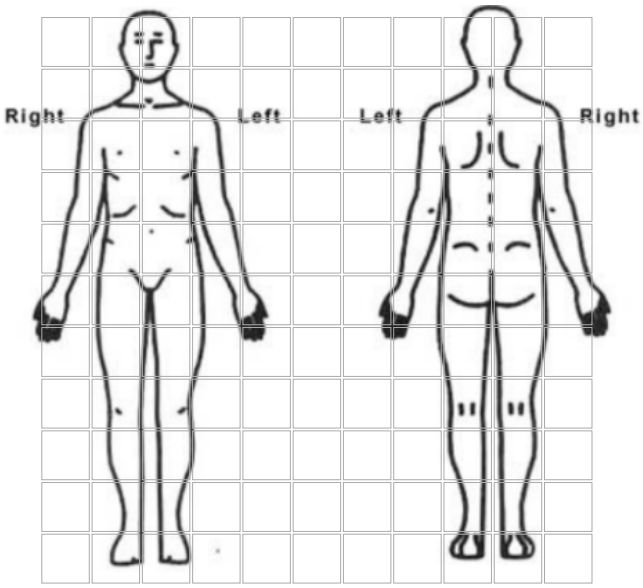
PAIN

Please mark on the below diagram where your pain is:



Describe the circumstances related to the onset of pain (accident, injury, illness, surgery, etc):

_____

_____

_____

Rate your level of pain today: 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10

Rate your level of pain on an average day: 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10

Describe your pain (circle all that apply): ACHING | STABBING | TENDERNESS | NAGGING | THROBBING | GNAWING | BURNING | NUMBNESS | SHOOTING | SHARP | EXHAUSTING | UNBEARABLE

SOAPP-R / POMI

The following section includes a quiz & consent form that are standard for all patients being treated for pain.**Even if we never prescribe ANY medications for you, we require these forms as a part of your record. Thank you for completing them to help us stay in compliance with all Nevada state laws & regulations**.

Please answer each question as honestly as possible, there are no right or wrong answers.

How Often...	NEVER	SELDOM	SOME TIMES	OFTEN	VERY OFTEN
Do you have mood swings?					
Have you felt a need for higher doses of medication to treat your pain?					
Have you felt impatient with your doctors?					
Have you felt that things are just too overwhelming & you can't handle them?					

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How Often...	NEVER	SELDOM	SOME TIMES	OFTEN	VERY OFTEN
Is there tension in your home?					
Have you counted pain pills to see how many are remaining?					
Have you been concerned that people will judge you for taking pain medication?					
Do you feel bored?					
Have you taken more pain medication than you were supposed to?					
Have you been worried about being left alone?					
Have you felt a craving for medication?					
Have others expressed concern for medication?					
Have any of your close friends had a problem with drugs or alcohol?					
Have others told you that you have a temper?					
Have you been consumed by the need to get pain medication?					
Have you run out of pain medication early?					
Have others kept you from getting what you deserve?					
Have you had legal problems, or been arrested?					
Have you attended an AA or NA meeting?					
Have you been in an argument that got out of control & someone was hurt?					
Have you been sexually abused?					
Have others suggested that you have a drug or alcohol problem?					
Have you had to borrow pain medication from family or friends?					
Have you been treated for an alcohol or drug problem?					

Do you ever…

Use more of your medication, that is, take a higher dosage than is prescribed for you? YES | NO

Use your medication more often, that is, shorten the time between doses? YES | NO

Feel high or get a buzz after using your pain medication? YES | NO

Take your pain medication to relieve or cope with problems other than pain? YES | NO

Go to multiple physicians including the ER, seeking more medications? YES | NO

Need early refills for your pain medication? YES | NO

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PATIENT CONSENT

Even if we never prescribe ANY medications for you, we require these forms as a part of your record. Thank you for completing them to help us stay in compliance with all Nevada state laws & regulations.

By initialing, I agree to the following:

_____ I will receive controlled substance prescriptions from only one physician or designated PA, and one pharmacy when possible.

_____ To prevent diversion of controlled substances such as selling, SFM and its designee have the right to urine/serum medication level screening whenever requested

_____ I certify that I have disclosed to my physician any past diagnoses or treatments of psychiatric conditions, drug or alcohol abuse.

_____ I have never been involved in the sale, illegal possession or transport of controlled substances such as narcotic, sleeping pills, pain pills or illegal substances such as marijuana, cocaine, “crack cocaine, methamphetamines, “crystal meth” or heroin.

_____ I agree to allow the physicians and designated staff at SFM to communicate with referring physicians, pharmacists and the DEA regarding my medication.

_____ I certify that I am not pregnant (if applicable), and if I am pregnant, I will notify the physician or the healthcare provider immediately.

_____ I understand that lost, stolen, or misplaced prescriptions or medication will generally not be replaced. Certain circumstances may be considered, but proof of a police report must be provided and filed.

_____ I agree to take my medication(s) as prescribed; I will not alter my dosage or timing of medications without consulting my physician or a provider at SFM.

_____ I agree that while I am being treated with narcotic medication, I will abstain from alcohol use. I understand the dangers involved in consuming alcohol and narcotic medication. I also understand that the narcotic medication may cause drowsiness. If I feel tired, or impaired, I will not operate a car or potentially dangerous machinery. Substance Abuse, which is defined as use of a controlled substance for non-therapeutic purposes; Addiction, which is defined as a psychological dependence characterized by compulsive use despite harm; Diversion, which is defined as a psychological dependence characterized by compulsive use despite harm; Diversion, such as selling the controlled substance.

_____ I understand that any infection or “break” of the normal routines established for the consumption of the prescriptions, or any suspicious deviation of the aforementioned will result in my being removed from medical treatment and care by SFM.

_____ I am aware and agree that I will need to make an appointment and be seen by a clinician to receive refills for all prescriptions for controlled substances.

I have read this form and freely consent to participate

Patient Signature:_____ Date:_____

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NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received the Notice ofPrivacy Practices which provides a description of information uses and disclosures. I understand that I have the right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree to the restrictions I request. I have also received a copy of the Patient's Bill of Rights.

Patient Signature_____ **Date**_____

I give authorization to leave a message on an answering machine or with anyone who answers at my phone number on file. These messages would be about scheduled appointments or a request to return the phone call.

Patient Signature_____ **Date**_____

I also give authorization to SFM medical staff to speak with _____ on my behalf, and to answer any questions this person may ask regarding my care.

HIPAA EMAIL CONSENT: In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information. The individual is also provided the right to request confidential communication or that a communication of the information may be obtained by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

☐ **I authorize Dr.Bowman & the entire staff of SFM to communicate any of my confidential medical information by email**

☐ **I decline the use of my email**

Patient Signature_____ **Date**_____

MEDICAL RECORDS RELEASE: By signing this form, I authorize to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician, person, facility, entity listed below. The information you may release subject to this signed release for is as follows:

Complete records including plan of care, pathology reports, hospital records, history and physical, lab reports, treatment record, medication record, progress notes, radiology and operative reports, ect.

Release my protected health information to the following physician, person, facility, entity; and/or those directly associated in my medical care: Summerlin Functional Medicine/Dr.John Bowman. 8811 W Sahara Ave #200 Las Vegas, Nevada 89117.

Patient Signature_____ **Date**_____

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INFORMED CONSENT FOR COVID TREATMENT

I give my consent for “off label” use of drugs including ivermectin, hydroxychloroquine, fluvoxamine, corticosteroids, atorvastatin, indomethacin, antihistamines (loratadine, cetirizine, fexofenadine, famotidine, nizatidine), mast cell stabilizers (rupatadine, sodium cromoglycate), montelukast, low dose naltrexone, diazepam, or SSRis, for the prevention and early treatment of COVID-19 / SARS2 and “Post COVID Syndrome” or “Long Haul COVID”. I also consent to additional drugs not listed but which are added to published treatment protocols by the flccc alliance and/or other medical sources deemed appropriate by Dr Bowman.

Name: _____

Signature: _____

Date: _____