Grapevine Functional Medicine
Wellness & Immune System Questionnaire

Name: ____________________ D.O.B.: _____ / _____ / ________ Today's Date: _____ / _____ / ________

Eyes/Nose/Throat	Current	Past	Never
Hard of hearing	☐	☐	☐
Deafness	☐	☐	☐
Ringing	☐	☐	☐
Discharge	☐	☐	☐
Earache	☐	☐	☐
Itching ears	☐	☐	☐
Decreased smell	☐	☐	☐
Bleeding nose	☐	☐	☐
Facial pain	☐	☐	☐
Nose obstruction	☐	☐	☐
Post nasal drip	☐	☐	☐
Deviated septum	☐	☐	☐
Seasonal allergies	☐	☐	☐
Chronic sinusitis	☐	☐	☐
Abnormal sneezing	☐	☐	☐
Sore throat	☐	☐	☐
Bad tonsils	☐	☐	☐
Throat pain	☐	☐	☐
Throat infections	☐	☐	☐
Burning/itchy eyes	☐	☐	☐
Facial sinus pain	☐	☐	☐
Sinus/head pressure	☐	☐	☐
Bleeding gums	☐	☐	☐
Mouth sores (canker)	☐	☐	☐
Bad breath	☐	☐	☐
Loss of taste	☐	☐	☐
Dry mouth	☐	☐	☐
Ulcers/blisters	☐	☐	☐
Antibiotic use	☐	☐	☐
Flu shot	☐	☐	☐
Allergy medication	☐	☐	☐

Gastrointestinal	Current	Past	Never
Acid reflux	☐	☐	☐
Gas/bloating	☐	☐	☐
Discomfort	☐	☐	☐
Diarrhea	☐	☐	☐
Constipation	☐	☐	☐
Intestinal disease	☐	☐	☐
Food allergies	☐	☐	☐
Constant hunger	☐	☐	☐
Crave sweets	☐	☐	☐
Nausea	☐	☐	☐
Endocrine	Current	Past	Never
Unexplained weight loss	☐	☐	☐
Unexplained weight gain	☐	☐	☐
Diabetes	☐	☐	☐
Thyroid disease	☐	☐	☐
Hot flashes	☐	☐	☐
Skin	☐	☐	☐
Color changes	Current	Past	Never
Nail changes	☐	☐	☐
Rashes/Irritation	☐	☐	☐
Sores	☐	☐	☐
Gout	☐	☐	☐
Shingles	☐	☐	☐
Fungus	☐	☐	☐
Psoriasis	☐	☐	☐
Warts	☐	☐	☐
Acne	☐	☐	☐
Keloids	☐	☐	☐
Psychiatric	Current	Past	Never
Anxiety	☐	☐	☐
Depression	☐	☐	☐

Pain	Current	Past	Never
Muscle weakness	☐	☐	☐
Joint pain	☐	☐	☐
Headaches	☐	☐	☐
Sports injuries	☐	☐	☐
Carpal tunnel	☐	☐	☐
Tendinitis	☐	☐	☐
Bursitis	☐	☐	☐
Disc problems	☐	☐	☐
Diabetic neuropathy	☐	☐	☐
Sciatica	☐	☐	☐
Fibromyalgia	☐	☐	☐
Back pain	☐	☐	☐
Neck pain	☐	☐	☐
Respiratory	Current	Past	Never
Phlegm	☐	☐	☐
Short of breath	☐	☐	☐
Wheezing	☐	☐	☐
Congestion	☐	☐	☐
Inhalant exposure	☐	☐	☐
Bronchitis	☐	☐	☐
Sleep	Current	Past	Never
Night sweats	☐	☐	☐
Insomnia	☐	☐	☐
Sleep apnea	☐	☐	☐
Nightmares	☐	☐	☐
Frequent waking	☐	☐	☐
Snoring	☐	☐	☐
Restless leg	☐	☐	☐

General	Current	Past	Never
Dizziness	☐	☐	☐
Fainting	☐	☐	☐
Tingling/numbness	☐	☐	☐
Fever	☐	☐	☐
Flus	☐	☐	☐
Chills	☐	☐	☐
Night sweats	☐	☐	☐
Unexplained perspiration	☐	☐	☐
High blood pressure	☐	☐	☐
Chronic illness	☐	☐	☐
Heart disease	☐	☐	☐
History of anaphylaxis	☐	☐	☐
Other conditions/concerns			
Please list below:	Current	Past	Never
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐

During which seasons do symptoms occur? ☐ Summer ☐ Fall ☐ Winter ☐ Spring

Are symptoms worse in the morning, afternoon, or evening? Explain:

Are symptoms worse at home, work/school, or other location? List:

Current OTC medications (list):

Current Rx medications (list):

Current supplements (list):

Previous surgeries (list):

Section 1

	Questions	Never/No	Rarely	Sometimes	Often	Always/Yes
1	Do you have excessive hunger?	0	1	2	3	4
2	Do you have food allergies?	0	1	2	3	4
3	Do you experience indigestion after meals?	0	1	2	3	4
4	Do you experience reflux?	0	1	2	3	4
5	Do you have abdominal bloating or feel gaseous after meals?	0	1	2	3	4
6	Do you feel fullness for extended times after eating (2-3 hours after meals)?	0	1	2	3	4
7	Does roughage or fiber give you constipation?	0	1	2	3	4
8	Do you have diarrhea after eating?	0	1	2	3	4
9	Do you experience low energy or get sleepy after eating?	0	1	2	3	4
10	Do you have difficulty breathing after eating?	0	1	2	3	4
		Subtotal				
					Total	

Section 2

	Questions	Never/No	Rarely	Sometimes	Often	Always/Yes
1	Do your muscles feel weak after performing normal daily activities?	0	1	2	3	4
2	Do you consume fewer than 3 servings of fruit and vegetables daily?	0	1	2	3	4
3	Do you consume fewer than 3 servings of whole grain daily?	0	1	2	3	4
4	Do you eat white flour products (breads, pasta, crackers, muffins, cookies, etc)?	0	1	2	3	4
5	Do you drink alcoholic beverages?	0	1	2	3	4
6	Do you drink soda or any carbonated beverages?	0	1	2	3	4
7	Do you use tobacco products?	0	1	2	3	4
8	Do you eat fried foods?	0	1	2	3	4
9	Do you feel nervous and unable to concentrate?	0	1	2	3	4
10	Do you have low energy and/or low stamina?	0	1	2	3	4
		Subtotal				
					Total	

Section 3

	Questions	Never/No	Rarely	Sometimes	Often	Always/Yes
1	Do you experience persistent illnesses?	0				4
2	Do you suffer from painful joints?	0	1	2	3	4
3	Do you have food allergies?	0	1	2	3	4
4	Do you drink alcoholic beverages?	0	1	2	3	4
5	Do you drink soda or any carbonated beverages?	0	1	2	3	4
6	Do you use tobacco products?	0	1	2	3	4
7	Do you eat chicken or red meat?	0	1	2	3	4
8	Do you get heartburn?	0	1	2	3	4
9	Do you have abdominal bloating or feel gaseous after meals?	0	1	2	3	4
10	Do you get constipated and/or have diarrhea?	0	1	2	3	4
		Subtotal				
					Total	

Section 4

	Questions	Never/No	Rarely	Sometimes	Often	Always/Yes
1	Do you experience fevers or infections?	0	1	2	3	4
2	Do you have disc problems?	0				4
3	Do you suffer from painful joints?	0	1	2	3	4
4	Do you experience difficulty in strengthening muscles?	0	1	2	3	4
5	Do your muscles feel very tight or congested?	0	1	2	3	4
6	Do you have muscle pain or cramps?	0	1	2	3	4
7	Are your injuries slow to heal?	0	1	2	3	4
8	Have you experienced any significant injuries in the last couple of months?	0				4
9	Are you or have you been on a high protein diet?	0				4
10	Do you have poor circulation or get cold hands and/or feet?	0	1	2	3	4
		Subtotal				
					Total	

Section 5

	Questions	Never/No	Rarely	Sometimes	Often	Always/Yes
1	Do you experience persistent illnesses?	0				4
2	Are you unable to get good results from antibiotics?	0	1	2	3	4
3	Do you have Candida Albicans?	0	1	2	3	4
4	Do you experience Athlete's Foot?	0	1	2	3	4
5	Do you experience fevers or infections?	0	1	2	3	4
6	Do you get fungal infections?	0	1	2	3	4
7	Do you get yeast infections?	0	1	2	3	4
8	Do you suffer from bad breath?	0	1	2	3	4
9	Do you have food allergies?	0	1	2	3	4
10	Do you experience anal itching?	0	1	2	3	4
		Subtotal				
					Total	

Section 6

	Questions	Never/No	Rarely	Sometimes	Often	Always/Yes
1	Do you have a history of joint injury?	0				4
2	Do you have arthritis?	0				4
3	Do you have bursitis or tendonitis?	0				4
4	Do you have extreme flexibility in your joints (double-jointed)?	0				4
5	Do you suffer from back pain?	0	1	2	3	4
6	Do you have pain in your fingers or wrists?	0	1	2	3	4
7	Do you have pain in your knees and/or hips?	0	1	2	3	4
8	Do you suffer from swollen joints?	0	1	2	3	4
9	Do your bones ache or feel painfully sore?	0	1	2	3	4
10	Do you wake up stiff and tight?	0	1	2	3	4
		Subtotal				
					Total	

Section 7

	Questions	Never/No	Rarely	Sometimes	Often	Always/Yes
1	Do you experience fevers or infections?	0	1	2	3	4
2	Do you get fever blisters or mouth ulcers?	0	1	2	3	4
3	Do you suffer from digestive ulcers?	0	1	2	3	4
4	Do you have seasonal allergies?	0	1	2	3	4
5	Do you have a high stress lifestyle?	0	1	2	3	4
6	Do you suffer from depression?	0	1	2	3	4
7	Do you feel nervous and unable to concentrate?	0	1	2	3	4
8	Do you have a hard time remembering things?	0	1	2	3	4
9	Do you have trouble falling asleep or staying asleep at night?	0	1	2	3	4
10	Do you have low energy and/or low stamina?	0	1	2	3	4
		Subtotal				
					Total	

Section 8

	Questions	Never/No	Rarely	Sometimes	Often	Always/Yes
1	Do you suffer from or have a family history of osteoporosis?	0				4
2	Do you have muscle pain or cramps?	0	1	2	3	4
3	Do you drink soda or any carbonated beverages?	0	1	2	3	4
4	Do you use tobacco products?	0	1	2	3	4
5	Do you get heartburn?	0	1	2	3	4
6	Do you have high blood pressure?	0	1	2	3	4
7	Are you 40 years of age or older?	0				4
8	Do you have restless leg syndrome?	0	1	2	3	4
9	Do you suffer from migraine type headaches?	0	1	2	3	4
10	Do you have trouble falling asleep or staying asleep at night?	0	1	2	3	4
		Subtotal				
					Total	

Section 9

	Questions	Never/No	Rarely	Sometimes	Often	Always/Yes
1	Do you experience fevers or infections?	0	1	2	3	4
2	Do you suffer from painful joints?	0	1	2	3	4
3	Do you have low iron?	0	1	2	3	4
4	Is your HDL (good cholesterol) low?	0				4
5	Is strokes or heart disease in your history (or family history)?	0				4
6	Do you have cataracts or poor eyesight?	0				4
7	Do you have cancer in your history or family history?	0				4
8	Do you have long bouts of stress?	0	1	2	3	4
9	Do you have trouble falling asleep or staying asleep at night?	0	1	2	3	4
10	Do you have low energy and/or low stamina?	0	1	2	3	4
		Subtotal				
					Total	

Section 10

	Questions	Never/No	Rarely	Sometimes	Often	Always/Yes
1	Do you have Candida Albicans?	0	1	2	3	4
2	Do you get fungal infections?	0	1	2	3	4
3	Do you get fungus under your fingernails or toenails?	0	1	2	3	4
4	Do you get yeast infections?	0	1	2	3	4
5	Do you have sugar cravings?	0	1	2	3	4
6	Do you have food allergies?	0	1	2	3	4
7	Do you eat white flour products (breads, pasta, crackers, muffins, cookies, etc)?	0	1	2	3	4
8	Do you drink alcoholic beverages?	0	1	2	3	4
9	Do you drink soda or any carbonated beverages?	0	1	2	3	4
10	Do you have seasonal allergies?	0	1	2	3	4
		Subtotal				
					Total	

Section 11

	Questions	Never/No	Rarely	Sometimes	Often	Always/Yes
1	Do you have arthritis?	0				4
2	Do you have chronic pain?	0				4
3	Do you have high cholesterol (over 200)?	0				4
4	Do you have cataracts or poor eyesight?	0				4
5	Do you look older than you are?	0				4
6	Do you suffer from a degenerative disease (MS, Rheumatoid Arthritis, Cancer)?	0				4
7	Do you have a high stress lifestyle?	0	1	2	3	4
8	Do you have a hard time remembering things?	0	1	2	3	4
9	Do you perform high-intensity work-outs?	0	1	2	3	4
10	Do you travel by air?	0	1	2	3	4
		Subtotal				
					Total	

Section 12

	Questions	Never/No	Rarely	Sometimes	Often	Always/Yes
1	Do you suffer from painful joints?	0	1	2	3	4
2	Do you suffer from stiffness of joints?	0	1	2	3	4
3	Are your injuries slow to heal?	0	1	2	3	4
4	Do you drink alcoholic beverages?	0	1	2	3	4
5	Do you have high cholesterol (over 200)?	0				4
6	Do you have high blood pressure?	0	1	2	3	4
7	Do you have seasonal allergies?	0	1	2	3	4
8	Is stroke or heart disease in your history (or family history)?	0				4
9	Do you suffer from depression?	0	1	2	3	4
10	Do you have a hard time remembering things?	0	1	2	3	4
		Subtotal				
					Total	

Section 13

	Questions	Never/No	Rarely	Sometimes	Often	Always/Yes
1	Do you experience persistent illnesses?	0				4
2	Do you get fever blisters or mouth ulcers?	0	1	2	3	4
3	Do you suffer from sinus problems?	0	1	2	3	4
4	Do you suffer from painful joints?	0	1	2	3	4
5	Do you have food allergies?	0	1	2	3	4
6	Do you have diarrhea after eating?	0	1	2	3	4
7	Do you have seasonal allergies?	0	1	2	3	4
8	Do you suffer from a degenerative disease (MS, Rheumatoid Arthritis, Cancer)?	0				4
9	Do you have a history of stomach or colon problems?	0				4
10	Do you get sick around the same time each year?	0				4
		Subtotal				
					Total	

Section 14

	Questions	Never/No	Rarely	Sometimes	Often	Always/Yes
1	How often do you have sugar cravings?	0	1	2	3	4
2	Do you have food allergies?	0	1	2	3	4
3	Do you have seasonal allergies?	0	1	2	3	4
4	How often do you experience indigestion after meals?	0	1	2	3	4
5	How often do you have abdominal bloating or feel gaseous after meals?	0	1	2	3	4
6	Do you have high cholesterol (over 200)?	0				4
7	Is your HDL (good cholesterol) low?	0				4
8	How often do you suffer from migraine type headaches?	0	1	2	3	4
9	How often do you have low energy and/or low stamina?	0	1	2	3	4
10	How often do you drink alcoholic beverages?	0	1	2	3	4
		Subtotal				
					Total	