Ketogenic Diet Intake Form

Marie Plawski, D.C, M.S
280 N Central Ave, Ste 211
Hartsdale, NY 10530

Date: _____

Please fill out entire form as completely as possible

Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____Cell Phone: _____ Home Phone:_____

E-mail Address: _____

Can we send you text msg for appointment reminders and notifications: _____

Marital Status: _____ # of Children: _____ Occupation: _____

Do you work FT or PT: _____ Primary Care Physician: _____

Address: _____

Phone: _____ Last Physical Exam: _____

Height: _____ Weight:_____ Weight Loss Goal: _____

Do you exercise?: Yes or No _____ If so, Please List Type of exercise below:

	Exercise	How Long?	How many times per week
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

How much time per day do you have for meal preparation each day? _____

What do you think your biggest obstacle is concerning losing weight? :_____

_____

_____

What interests you about the Ketogenic Diet? _____

_____

What other diets have you tried in the last 5 years:_____

_____

_____

What is the most amount of weight you ever lost on a any 1 diet? _____ lbs.
What was the diet and how long did it take: _____

Are you familiar or do you own an app for tracking weight loss? For example: MyFitnessPal?
Circle: Yes No Name of App: _____

Please check off meats that you will eat on this diet:

__ Chicken
__ Pork
__ Beef
__ Fish
__ Lamb
__ Veal
__ I am a vegetarian
__ I am a vegan

Please Check off which products you would like to include in this diet.

__ Onions
__ Mushrooms
__ Eggs
__ Nuts
__ Cheese
__ Butter (regular or Clarified)
__ Milk
__ Heavy cream
__ Avocado
__ Seafood
__ Olives
__ Capers
__ Coconut
__ Goat Cheese
__ Bacon
__ Coffee
__ Pastrami

What are your favorite green vegetables : _____

_____

What green vegetables will you not eat? _____
_____

How often do you snack per day? _____ How many servings of bread do you eat in a day: __
How much sugar do you intake a day (including fruit)? Very Little Moderate A lot
How committed are you to losing weight? Check off below.
__ I just want to try the Ketogenic Diet
__ I want to try it and lose some weight
__ I want to lose the maximum amount of weight to reach my target weight.

Is there anything that might stop you from reaching your goal: _____
_____
_____

Health History:
Please list all medications you are currently taking and for what condition. Can use back of page if more room necessary.

	Medication Name	MG	Reason
1.			
2.			
3.			
4.			
5.			
6.			

Do you smoke? ____ if yes, how much per day, week? _____ How Long? _____
If you quit, When:_____
Do you drink alcohol? If so, what kind: _____ How often: _____
Are you willing to give up alcohol on this diet? _____. (If applicable)

Do you have or ever had the following:
__ Cancer, if yes when and what type? _____
__ Heart Condition What type? _____
__ Diabetes? If yes, What type: _____
__ Hyperglycemia
__ Thyroid condition. Hyper or Hypo? Other: _____
__ High Blood Pressure
__ Low Blood Pressure
__ Eating Disorder. If yes, What Kind:_____ Circle: Active Or Inactive
__ Attention Deficit or Dyslexia
__ Difficulty Swallowing

Do you have any gastrointestinal disorders? Circle. Yes Or No

What type? Please check off:

__ IBS
__ Crohn's Disease
__ SIBO
__ Constipation
__ Frequent Diarrhea
__ Bloating
__ Abdominal Pain
__ Other: _____

Are you currently under medical care for any disease or mental health condition?
If so, please explain: _____
_____
_____
_____

Do you currently suffer from any of the following:
__ Hot Flashes (Women)
__ Low Testosterone
__ High Testosterone
__ Night Sweats: How often: _____ per day/month/year
__ Headaches. How often: _____ per day/month/year
__ Fatigue. How often: _____ per day/month/year
__ Mood Swings. How often: _____ per day/month/year
__ Depression. How often: _____ per day/month/year
__ Skin rashes or skin condition. If so, please list _____
__ Seizures. If yes, explains: _____
__ Memory problems
__ Lack of concentration or "Brain Fog". How often: _____ per day/month/year
__ Stress. Circle one: High level Moderate level Mild level Rarely Occasionally
__ Difficulty Sleeping. Average hours per night of sleep: _____
__ Osteopenia or Osteoporosis
__ Vision Problems or Eye Disease: Explain: _____
__ Arthritis. If so, What kind and Where? _____
__ Do you suffer from chronic pain? If so, where? _____

Please list any surgeries you have had in the past or scheduled for the future. _____
_____
_____
_____

The Ketogenic Diet is a very low carbohydrate, high fat and moderate protein diet. To achieve positive results this diet has to be very low in carbohydrate, high in dietary fat and moderate amount of protein. This reduction of carbohydrate puts your body into a metabolic state called ketosis. When this happens, your body becomes incredibly efficient at burning fat for energy. The Ketogenic Diet can cause a large change and reduction in blood sugar, insulin level and help with weight loss. Other benefits can be improved sleep and mood and increased energy efficiency.

I understand the above and have filled out the above Intake Forms to the best of my knowledge and ability. I further understand that the materials and products provided to me are to assist me with weight loss and is not a guarantee of weight loss.

_____

Signature of Patient