AIP Diet Plan

AIP DIET PLAN

Name: _____ Date: _____ dd / mm / yyyy

Date of Birth: _____ dd / mm / yyyy Gender: _____

Height: _____ Weight: _____

Previous medical history (i.e., related to symptoms bloating, pain)

Current health status (e.g., symptoms and experiences):

Baseline diet

Suspected food items (i.e., food items causing symptoms)

Suspected food items

- [ ] Gluten
- [ ] Dairy
- [ ] Additives
- [ ] Refined sugars
- [ ] Grains

ELIMINATION PHASE

Foods to eliminate:

Substitutes:

PROGRESS

Date: _____ dd / mm / yyyy

Notes

REINTRODUCTION PHASE

Foods to reintroduce:

Nutritional Guidance:

Recommendations:

PROGRESS

Date: _____ dd / mm / yyyy

Notes

MAINTENANCE PHASE

Final inflammatory food list:

Additional notes