

Dietary Restrictions Form

Please check any of the following dietary restrictions that apply to you:

- Lactose intolerant or milk allergies (dairy free)
- Vegetarian (will eat animal products, but not meat, poultry, and fish)
- Vegan (no animal products whatsoever)
- Religious dietary practices
- Diabetic diet
- Gluten free
- Autoimmune Disorder
Please specify: _____

Please list any food allergies you have:

Please list foods that you may not eat due to Autoimmune Disorder/dietary restrictions:

Patient Name (please print):

Patient Signature: _____

Date: _____

Parent/Guardian Signature (if participant is under 18 years of age):
