

AIP Diet Plan

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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