Dietary Restriction Form

Full Name: _____
Date of Birth: _____
Gender: _____
Address: _____
Phone Number: _____
Email: _____

Emergency Contact

Name: _____
Relationship: _____
Phone Number: _____

Primary Care Physician

Physician Name: _____
Phone Number: _____
Address: _____

Health Insurance Information

Insurance Provider: _____
Policy Number: _____
Group Number: _____

Dietary Restrictions

1. Allergies (specify food items and type of reaction):
   - _____
   - _____
2. Intolerances (specify food items and symptoms):
   - _____
   - _____
3. Medical Conditions Requiring Dietary Restrictions (e.g., diabetes, celiac disease, hypertension):
   - _____
   - _____
4. Medications Affecting Diet (include dosage and frequency):
   - _____
   - _____

Specific Dietary Needs

1. Foods to Avoid:
    - _____
    - _____
2. Preferred Foods:
    - _____
    - _____
3. Nutritional Requirements:
    - _____
    - _____

Eating Habits and Preferences

1. Meal Preferences (e.g., vegetarian, vegan, kosher, halal):
    - _____
    - _____
2. Favorite Foods:
    - _____
    - _____
3. Disliked Foods:
    - _____
    - _____
4. Meal Frequency and Timing:
    - _____
    - _____

Special Instructions

- Texture Preferences (e.g., soft foods, liquid diet):
    - _____
    - _____
- Beverage Preferences:
    - _____
    - _____
- Additional Notes or Special Instructions:
    - _____
    - _____

_____

Consent and Acknowledgement

I acknowledge that the information provided above is accurate and complete to the best of my knowledge. I authorize [Personal Care Agency Name] to use this information to create and manage my dietary plan.

Client Signature: _____ Date: _____

Caregiver/Agency Representative Signature: _____ Date: _____

This form is confidential and will be used solely to provide personal care services and ensure the client's dietary needs are met.