# CLINICIAN'S ASSESSMENT CHECKLIST FOR KETOGENIC DIET

Patient Name: ____________________________________________ Date: __________________

What health problems would you like to address with a Ketogenic Diet?

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Do you currently have or have a history of any of the following conditions?

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| ☐ Carnitine deficiency (primary) | ☐ Succinyl-CoA acetoacetate transferase (SCOT) deficiency |
| ☐ Carnitine palmitoyltransferase I or II deficiency | ☐ Beta-ketothiolase (T2) deficiency |
| ☐ Carnitine translocase deficiency | ☐ Methylmalonyl-CoA epimerase deficiency |
| ☐ β-oxidation defects | ☐ Porphyria cutanea tarda |
| ☐ Medium-chain acyl dehydrogenase deficiency | ☐ Porphyria |
| ☐ Long-chain acyl dehydrogenase deficiency | ☐ Excess alcohol intake / Alcohol dependence |
| ☐ Short-chain acyl dehydrogenase deficiency | ☐ Itching, blistering triggered by exposure to sunlight |
| ☐ Long-chain 3-hydroxyacyl-coenzyme A deficiency | ☐ Abnormal symptoms triggered by use of alcohol |
| ☐ Medium-chain 3-hydroxyacyl-coenzyme A deficiency | ☐ Any disordered eating |
| ☐ Pyruvate carboxylase deficiency | ☐ Anorexia or bulimia |

**If you've checked any of the above boxes, STOP here and contact our office. The ketogenic diet is contraindicated and is not recommended for you.**

Do you currently have or have a history of any of the following conditions?

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| ☐ Any persistent medical symptoms that have never been explained | ☐ High cholesterol |
| ☐ Underweight, unwanted weight loss | ☐ High triglycerides |
| ☐ Issues with kidneys | ☐ Dehydration |
| ☐ Kidney stones | ☐ Chronic constipation |
| ☐ Issues with liver | ☐ Decreased bone density, or frequent fracture |
| ☐ Hepatitis C | ☐ Difficult chewing or swallowing |
| ☐ Issues with gallbladder | ☐ Neurological impairment |
| ☐ Gallstones | ☐ Cancer |
| ☐ Issues with pancreas | ☐ Cancer cachexia |
| ☐ Issues with stomach | ☐ Type I Diabetes |
| ☐ Issues with intestines | ☐ Type II Diabetes |
| ☐ Issues with thyroid gland | ☐ High blood glucose (fasting glucose or HbA1c) |
| ☐ Issues with heart | ☐ High blood pressure |
| ☐ Gout | |

**If you've checked any of the above boxes, the ketogenic diet warrants close medical supervision.**

## DIETARY HISTORY

| | | |
|---|---|---|
| Do you regularly consume animal products? | ☐ YES | ☐ NO |
| Are you following a vegan or vegetarian diet? | ☐ YES | ☐ NO |
| If so, for how long and for what reasons: ______________________________ | | |
| Have you ever attempted a carbohydrate-restricted or high-fat diet before? | ☐ YES | ☐ NO |
| Have you ever attempted a low-fat diet before? | ☐ YES | ☐ NO |
| Have you ever fasted? | ☐ YES | ☐ NO |
| Have you ever measured your ketone level? | ☐ YES | ☐ NO |
| Have you ever tracked your calorie or macronutrient intake? | ☐ YES | ☐ NO |

## FOOD ALLERGIES

| Please list any of your food allergies: |
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## FOOD SENSITIVITIES OR INTOLERANCES

| Please list any of your food sensitivities or intolerances: |
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## FOOD AVERSIONS

| Please list any of your food aversions: |
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|---|---|---|
| Do you drink alcohol? | ☐ YES | ☐ NO |
| If so, how much per week? ____________________ | | |
| Do you have trouble digesting protein? | ☐ YES | ☐ NO |
| Do you have trouble digesting fats? | ☐ YES | ☐ NO |
| Would you describe yourself as a “picky eater”? | ☐ YES | ☐ NO |

| How would you describe your appetite? |
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## COOKING ENVIRONMENT

| | | |
|---|---|---|
| Do you cook? | ☐ YES | ☐ NO |
| If no, who does? ______________________________ | | |
| Do you like to cook? | ☐ YES | ☐ NO |
| Do you like to follow recipes or meal plans? | ☐ YES | ☐ NO |
| Do you have a slow cooker, blender, food processor? | ☐ YES | ☐ NO |
| How much time do you have to devote to cooking and food preparation on weekdays? ______________ | | |
| How much time do you have to devote to cooking and food preparation on weekends? ______________ | | |
| How often do you eat out? ______________________________ | | |
| Where do you most often eat out? ______________________________ | | |
| Do others in your household have any dietary restrictions? | ☐ YES | ☐ NO |
| Do you have any financial concerns about purchasing high quality, whole foods? | ☐ YES | ☐ NO |

## SOCIAL ENVIRONMENT

| | | |
|---|---|---|
| Are your family/friends supportive of your dietary changes? | ☐ YES | ☐ NO |

| What social gatherings might be difficult if you have dietary restrictions? |
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| Do you have any specific social events coming up that you will need to navigate in the context of a new diet? |
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## READINESS TO CHANGE

**Rate the each questions using this 1-5 scale: 1 = Not Willing and 5 = Very Willing**

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|---|---|---|
| Are you willing to change what you eat, even if that means giving up certain foods? | | |
| Are you willing to track calories or macronutrients for each meal and snack? (Most likely for a short period only, at the onset of the diet. Support will be provided.) | | |
| Are you willing to undertake a periodic Nutrient Intake Analysis (including micronutrients) to evaluate potential dietary deficiencies? | | |
| Do you have concerns about implementing a Ketogenic Diet? | ☐ YES | ☐ NO |
| If so, please describe: | | |
| | | |
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## PHYSCIAN AUTHORIZATION

| | | |
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| Do you have physician approval to commence a Ketogenic Diet? | ☐ YES | ☐ NO |
| Has your physician agreed to monitor you while you are on a Ketogenic Diet? | ☐ YES | ☐ NO |

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### For Office Use Only

| | |
|---|---|
| Height | |
| Weight | |
| BMI | |
| Waist Circumference | |
| Hip Circumference | |
| Waist / Hip Ratio | |
| Body fat % | |
| Blood Pressure | |