


Because we are partners in your healthcare,  
 please choose ONE of these areas where you would like  
 to improve in your health.

Name: \_\_\_\_\_ Date \_\_\_\_\_

**Aerobic Exercise Goal**

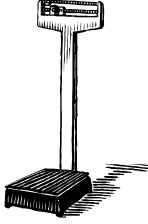


- Walking
- Biking
- Running
- Swimming
- Other \_\_\_\_\_

Minutes a day \_\_\_\_\_  
 Days a week \_\_\_\_\_

**Weight Loss Goal**

My weight loss goal is:




- # \_\_\_\_\_ pounds a week
- # \_\_\_\_\_ pounds by \_\_\_\_\_  
 Weight loss program?  
 \_\_\_\_\_

**Tobacco Use**

I will . . .

- Cut back to: \_\_\_\_\_
- Quit Date: \_\_\_\_\_

Plan for Quitting




\_\_\_\_\_

\_\_\_\_\_

**Dietary Goal #1**


I will INCREASE



- Vegetables
- Fruit
- Protein
- Fiber
- Water
- Other \_\_\_\_\_

**Dietary Goal #2**

I will DECREASE



- Carbohydrates
- Fats
- Sweets
- Salt
- Caffeine
- Alcohol
- Soda
- Eating Out
- Other \_\_\_\_\_


**Other Short Term Goal**

\_\_\_\_\_

\_\_\_\_\_


\_\_\_\_\_

How can The Family Practice Staff help? \_\_\_\_\_



\_\_\_\_\_

**Monitoring**




I will . . .

Frequency

- Check my Blood Sugar \_\_\_\_\_
- Check my Blood Pressure \_\_\_\_\_
- Check my weight \_\_\_\_\_
- See my eye doctor \_\_\_\_\_

Date of last visit \_\_\_\_\_  
 With Dr. \_\_\_\_\_

**Stress Management**



I will . . .

- Decrease Commitments
  - Reassess Priorities
  - Improve Efficiency
  - Get Adequate Sleep
  - Schedule Time Off
  - Address Relationship Issues
  - Pursue Hobbies
- Other: \_\_\_\_\_

**Support Plan**

Support/ Accountability Person:

- Spouse
- Friend
- Other \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Provider Signature \_\_\_\_\_ Date \_\_\_\_\_



ERROR: undefined  
OFFENDING COMMAND:

STACK: