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

Name: _____ Date _____

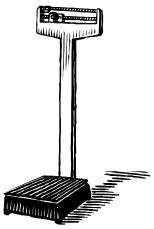
Aerobic Exercise Goal

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 _____