My Action Plan

Name:_____ Date:_____

❑ I have worked with another provider to set a goal.

1 What I Will Do

Choose One:

- ❑ Improve my physical activity.
- ❑ Take my medications.
- ❑ Improve my food choices.
- ❑ Reduce my stress.
- ❑ Change my tobacco use.
- ❑ Other:_____

Specifically I will:
(Example: Walk more.)_____

Why?_____

2 How Much/How Often

How much:
(Example: 20 minutes)_____

How often:
(Example: Three times a week.)_____

When:
(Example: Monday, Wednesday, Friday)_____

3 Confidence

How confident are you that you will be able to do the activity?
(Circle one. Choose an activity where you would be a 7 or above.)

0 1 2 3 4 5 6 **7** **8** **9** **10**

Not sure at all — Somewhat sure — Very sure

_____
My signature

_____
Healthcare provider signature

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