My Action Plan

Name:______________________________ Date:______________________

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

What I Will Do

1

Choose **One** Goal:

I will____

(Examples: Increase my physical activity,
Take my medications, Make healthier food choices,
Reduce my stress, Reduce my tobacco use.)

?

Specifically I will____

(Examples: Walk more, Eat more fruits and vegetables.)

Why?____

How Much/How Often

2

How much:
(Example: 20 minutes)____

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

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

Confidence

3

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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