

My Self-Care 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)

Choose **One** Action:

I will _____.

(Examples: walk more; eat more fruits and vegetables)



.....

How Much/How Often

2

How much: _____

(Example: 20 minutes)

How often: _____

(Example: three times a week on Monday, Wednesday, and Friday)

.....

Confidence

3

Circle a number to show how sure you are about doing the activity. Try to choose an activity that you are 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