



# My Healthy Lifestyle

## Self management goal form (18 years and up)

Patient name \_\_\_\_\_  
 Date of birth \_\_\_\_\_  
 Daytime phone # \_\_\_\_\_  
 Address \_\_\_\_\_  
 City/State/Zip \_\_\_\_\_  
 Today's date \_\_\_\_\_

Follow up time frame:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### Goal setting

#### 1. Choose an activity goal below:



Get more physically active!



I will monitor my portion size and weigh my food.



I will make healthier choices with my meals.



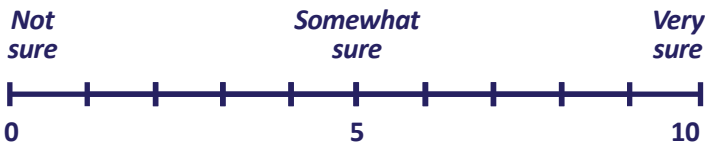
I will eat least 3–5 servings of vegetables and fruit per day.



I will eat healthier snacks.

#### 2. Choose your confidence level:

I think I can succeed at this goal:



#### 3. Fill in the following for your chosen goal:

What: \_\_\_\_\_

\_\_\_\_\_

When: \_\_\_\_\_

\_\_\_\_\_

How much: \_\_\_\_\_

\_\_\_\_\_

How often: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Barriers to meeting goals: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Clinician signature

