My Healthy Lifestyle

Self management goal form (17 years and under)

Patient name ______________________________

Date of birth ______________________________

Daytime phone # ______________________________

Address ______________________________

City/State/Zip ______________________________

Today's date ______________________________

Follow up time frame:

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Goal setting

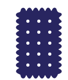
1. Choose an activity goal below:

❑ Get more physically active!

❑ I will eat more vegetables dailiy.

❑ I will eat more fruit daily.

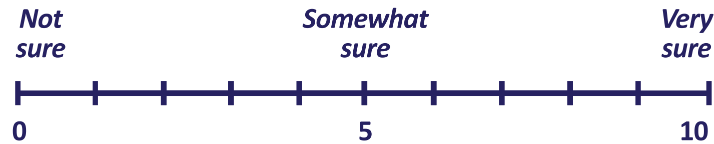
❑ I will limit fruit juice to 4 oz. per day.



❑ 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: ______________________________

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Clinician signature