Date: Pt name:

Clinic: ________________________

Healthy Behavior Action Plan

These behaviors impact your health. There is a space is for something that you feel is important, but isn't yet on here. Cross out what doesn't apply to you.

Is there anything that you would consider doing this week to improve your health?

Work on
something
else:

My *Action Plan* will be:

What?:

Where?:

How often?:

Who can support me? :

This is how sure that I will be able to do this (circle one):

Not sure Very sure

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

Medical provider follow-up will be:

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