AMERICAN ACADEMY OF FAMILY PHYSICIANS

My Action Plan

Patient name: _____ **Date:** _____

This is my health care goal – what I want to change:

_____

Things I can do to help achieve this goal:

1. _____
2. _____
3. _____
4. _____

(CIRCLE 1, 2, 3, or 4 ABOVE TO WORK ON BETWEEN THIS VISIT AND YOUR NEXT APPOINTMENT ON _____.)

My action steps:

What I will do: _____

_____

How often: _____

_____

When: _____

_____

What are the potential barriers? _____

_____

How will I overcome these barriers? _____

_____

Support and resources that could help me accomplish this goal: _____

_____

On a scale of 1 (low) to 10 (high), my confidence in reaching this goal is: _____

What would help me increase my confidence? _____

_____

Date/time for telephone follow-up: _____

Date/time for next appointment: _____

Other follow-up if needed: _____