

Action Plan: My Prescription for a Healthy Weight

Set S.M.A.R.T. goals: **S**pecific (what you are going to do and how often), **M**easurable (how you will know if you have done it each day), **A**ttainable (can you do it?), **R**ealistic (can you do it given everything going on now?), and **T**ime Limited (when will you do this by?).

Name: _____ **Date:** _____

Current Weight: _____ **Current BMI:** _____ **Goal Weight:** _____

A 5-10% reduction in my weight can have a beneficial effect on my health. Achieving a healthy weight and becoming more active would help me manage some of my health problems, including:

- | | | |
|--|--|---------------------------------------|
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Depression |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma/COPD |
| <input type="checkbox"/> Sleep apnea | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Other: _____ |

My goal weight is _____ and I will work to achieve that goal by ____/____/____ by following my Action Plan.

My Action Plan

My Action Plan consists of things I agree to do and support that medical professionals and others can provide. Both parts of my Action Plan are important in helping me reach my goals.

1. What I will do

My Nutrition Goals

I will:

- Monitor my daily intake using a journal. *Optional:* Eat _____ calories or _____ points/day.
- When eating out, share or bring home half of the entrée.
- Limit the use of added fats such as salad dressing, mayonnaise, peanut butter, margarine, butter and oil.
- Consume five servings of fruits and vegetables per day.
- Replace sweetened beverages like soda, coffee drinks or fruit drinks with water or low-calorie substitutes.
- Avoid eating fast food.
- Other: _____

My Physical Activity Goals

I will:

- Take the stairs whenever possible.
- Use a pedometer to track my steps. Walk 8,000-10,000 steps per day.
- Walk instead of driving one mile to a store.
- Walk/ Bike/ Swim _____ minutes _____ times per week.
- Park farther away.
- Other: _____

2. Support from my Care Team

- Referral to other professional:
 - » Name: _____
 - » Phone number: _____
- Medication – prescribed or over-the-counter: _____
- Community resources referral: _____

I understand that follow-up will be important as I lose weight. I agree to follow up with _____ about every _____ weeks. If I have questions or concerns between visits, I should call _____.
 Phone number: _____.