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:

- High cholesterol
- High blood pressure
- Sleep apnea
- Heart disease
- Diabetes
- Arthritis
- Depression
- Asthma/COPD
- Other: ______________________

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

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: ____________________.

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:__________________________________________________________________________