



You may want to change logo to your practice name in this space

Healthy Weight Change Plan

Name _____

It is preferable to only set one goal. Two goals should be the maximum. For families not ready to make a change, let them take the plan home and think about making a change.

SETTING A GOAL

Here are some things other people have decided to do for their health. I would like to _____

- Eat at least 5 servings of fruits/vegetables a day
- Reduce sugar-sweetened beverages
- Get at least 60 minutes of physical activity every day
- Limit screen time (especially TV)
- Increase water intake
- Get enough sleep
- Other _____

ACHIEVING MY GOAL

Explore the reasons for their choices here.

1. How ready am I to make this change? (select a number)
0 1 2 3 4 5 6 7 8 9 10
Not at all ready *Ready to start today*

2. What might make it difficult for me to achieve my goal (what are the barriers)?

3. Steps I will take to make this change (for example: what, when, how and with whom):
a. _____
b. _____
c. _____
d. _____

See pages 20-22 for some suggestions.

4. How confident am I that I can carry out this plan? (select a number)
0 1 2 3 4 5 6 7 8 9 10
Not at all confident *Very confident*

5. Information or support I might need in accomplishing my goal:

6. I will know my plan is working when:

7. I will celebrate my success by:

8. I agree to this plan of action and will review my plan and progress on _____ with _____
by _____ (Date) _____ (Name)

REFERRALS AND FOLLOW UP

- I need more information about how to improve my health! I want to:
- Follow up with my primary care doctor, _____
 - See a dietitian to talk about healthy eating
 - Be referred to community agencies where I can exercise

Consider a community or other health care professional referral when necessary

I give my permission to forward the information about my health assessment and my plan to the health professional I want to see.

Signature of individual _____ Date _____



Healthy Weight Change Plan

Name _____

SETTING A GOAL

Here are some things other people have decided to do for their health. I would like to set goal(s) to:

- Eat at least 5 servings of fruits/vegetables a day
- Eat breakfast everyday
- Reduce sugar-sweetened beverages
- Manage my stress
- Get at least 60 minutes of physical activity every day
- Get enough sleep
- Limit screen time (especially TV)
- Other _____

ACHIEVING MY GOAL

1. How ready am I to make this change? (select a number)

0 1 2 3 4 5 6 7 8 9 10
Not at all ready *Ready to start today*

2. What might make it difficult for me to achieve my goal (what are the barriers)?

3. Steps I will take to make this change (for example: what, when, how and with whom):

- a. _____
- b. _____
- c. _____
- d. _____

4. How confident am I that I can carry out this plan? (select a number)

0 1 2 3 4 5 6 7 8 9 10
Not at all confident *Very confident*

5. Information or support I might need in accomplishing my goal:

6. I will know my plan is working when:

7. I will celebrate my success by:

8. I agree to this plan of action and will review my plan and progress on _____ with _____
by _____ (Date) _____ (Name)

REFERRALS AND FOLLOW UP

I need more information about how to improve my health! I want to:

- Follow up with my primary care doctor, _____ (Name) by _____ (date)
- See a dietitian to talk about healthy eating
- Be referred to community agencies where I can exercise

I give my permission to forward the information about my health assessment and my plan to the health professional I want to see.

Signature of individual _____ Date _____

Annotated Healthy Weight Change Plan

Photocopy the plan on the next page and work through it with patients and families when behavior change is needed. You can begin by asking patients and families if they agree it is important to make a change.

The questions should be answered by the patients and family, not the clinician.

One copy of the plan can go home with the family; another can be kept in the patient's chart for follow-up.

If a family is not ready to discuss or commit to a change, let them take the plan home to help them think about making a change.

Note that healthy weight children may also benefit from improving their habits.

You may want to stamp your practice name in this space.

Date _____

HOW READY AM I TO MAKE THIS CHANGE?

5 6 7 8 9 10 **Very Ready**

NUTRITION

OR

PHYSICAL ACTIVITY

Change:

Explore the reasons for their choices here. "I see you chose X. Why not something lower/higher?" Once they give their barriers and concerns, follow up with "But on the other hand, X isn't 0. Can you tell me more about your choice?"

Change:

It is preferable to only set one goal. Two goals should be the maximum.

What will help me make this change?

What will help me make this change?

See pages 20-22 for some suggestions.

Who or what can help me?

My strengths:

My family's strengths:

Who or what can help me?

My strengths:

My family's strengths:

What can get in the way?

What can get in the way?

HOW CONFIDENT AM I THAT I CAN MAKE THIS CHANGE?

Not Confident 1 2 3 4 5 6 7 8 9 10 **Very Confident**

Explore the reasons for their choice.

PATIENT SIGNATURE _____

PARENT SIGNATURE ← _____

Parent signature might not be necessary for adolescents.

SIGNATURE

Healthy Weight Change Plan



Date _____

HOW READY AM I TO MAKE SOME HEALTHY CHOICES ABOUT ACTIVITY AND EATING?										
Not Ready										Very Ready
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10	

NUTRITION
Change:
What will help me make this change?
Who or what can help me? My strengths: My family's strengths:
What can get in the way?

OR PHYSICAL ACTIVITY
Change:
What will help me make this change?
Who or what can help me? My strengths: My family's strengths:
What can get in the way?

HOW CONFIDENT AM I THAT I CAN MAKE THIS CHANGE?										
Not Confident										Very Confident
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10	

PATIENT SIGNATURE _____

PARENT SIGNATURE _____

CLINICIAN SIGNATURE _____