HEALTHY LIVING ACTION PLAN

Name: _____

Medical Provider's	Clinical Case Manager's
Name: _____	Name: _____
Phone: _____	Phone: _____

QUIT SMOKING:

- ☐ **Call the Vermont Quit Line at 1-800-QUIT-NOW (1-800-784-8669) for counseling, self-help materials, local program referrals, and help getting free nicotine patches, gum, or lozenges.**

PROTECT YOURSELF:

- ☐ Wear helmets, seat belts, sunscreen, and insect repellent.
- ☐ Wash hands frequently to stop the spread of germs.
- ☐ Avoid smoking and breathing the smoke of others.
- ☐ Build safe and healthy relationships with family and friends.
- ☐ Be prepared for unexpected emergencies. Have a supply kit and include your medications.

BE ACTIVE:

- ☐ Be active for at least 2½ hours a **week. Include activities that raise your** breathing and heart rate and that **strengthen your muscles.**
- ☐ Help children and teens be active for at least 1 hour a day. Include activities that raise their breathing and heart rates and **that strengthen their muscles and bones.**

MANAGE STRESS:

- ☐ Balance work, home, and play.
- ☐ Get support from family and friends.
- ☐ Stay positive.
- ☐ Take time to relax.
- ☐ Sleep 7 to 9 hours each night depending upon age. Children may need more sleep.
- ☐ Get help or counseling if needed.

For more information on these or other health topics, call us toll-free at 1-866-900-5004.

EAT HEALTHY:

- ☐ **Eat a variety of fruits, vegetables, and whole grains every day.**
- ☐ **Limit food and drink high in calories, sugar, salt, fat, and alcohol content.**
- ☐ Eat a balanced diet to help keep a **healthy weight.**
- ☐ Include fat-free or low-fat milk and milk **products daily.**
- ☐ **Include lean meats, poultry, fish, beans, eggs, and nuts daily.**
- ☐ **Avoid adding sugar to drinks, tea, and coffee.**

GET CHECK UPS:

- ☐ Based on your lifestyle, personal and **family health histories, ask your provider** how you can lower your risk for health problems.
- ☐ **Find out what exams, tests, and shots** you need and when to get them.
- ☐ See your provider sooner if you feel **sick, have pain, notice changes, or have problems with medicine.**

HEALTHY LIVING ACTION PLAN

MY ACTION PLAN

Goal: Something I WANT to do (Example: increase physical activity, take medication, make healthier food choices, etc.)	Action: A specific activity that you are going to do in the next 1 to 2 weeks. (Example: I will walk for 30 minutes after dinner with my dog three days each week for the next two weeks.)

What you will do (the behavior):

How much you will do (time, distance, or amount of activity):

When you will do it (time of day):

How often you will do it (number of days per week):

How important is it to you that you complete the action plan you made above? (Fill in your response.)

Not at all important ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10 Totally important

How confident are you that you will successfully complete the action plan you made above? (Fill in your response.)

Not at all confident ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10 Totally confident

Things that might make it hard:

Ways I might overcome these problems:

Follow-up plan (phone or e-mail and date/time):