

Feelings Action Plan – Self Management Goals

Patient's Name: _____

PID#: _____

Date: _____



My doctor and I have agreed that I/My child have this problem:

My/My child's goal is:

Child

I agree to do the following:

1. _____

2. _____

3. _____

4. _____

5. _____

Parent

I will help my child with the following:

1. _____

2. _____

3. _____

4. _____

5. _____

We will work on these things until our next visit – _____ / _____ / _____

Patient's Signature: _____

Date: _____

Parent's Signature: _____

Date: _____

Doctor's Signature: _____

Date: _____



Be Active.

Every day during the next week I will spend _____ minutes doing _____



Eat well.

On Monday; Tuesday; Wednesday; Thursday; Friday; Saturday; Sunday (circle days) I will eat _____



Practice relaxation – deep breathing, robot/rag doll, find a quiet place...

Every day during the next week I will spend _____ minutes doing _____



Sleep well.

Every night during the next week I will spend _____ hours sleeping or quietly resting.



Have fun!

Every day next week I will spend _____ minutes doing _____

