My Healthy Living Plan

THE W.E.L.L. CLINIC
by Children's Primary Care Medical Group

name:________________________ date: __________

What am I doing now? (I refers to child if parent is completing survey)

nutrition

How many times a day I eat **fruits or vegetables**? __________
How many times a day I drink **sugar sweetened drinks** (soda, sports drinks, juice, swetened tea, lemonade) or 100% juice? __________
How many times a day I eat **"junk" food** (cake, cookies, chips, etc.)? __________
How many times a day I eat **takeout or fast food**? __________

exercise and physical activity

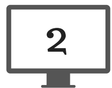
On most days, how many minutes do I spend in **active play or exercise** (fast breathing, sweating)? _______ days _________time
How many hours a day do I watch TV/movies or sit and play video games or use the cell phone, computer, or tablet for fun? _________

other habits

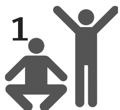
How many times a week do I skip meals? __________
How many days a week do I have trouble sleeping? _______
How many times a week do I eat dinner at the table with my family? _______
I have a TV or phone in the room where I sleep? Yes ______ No______

I will try at least one goal. (No more than 3 goals)

Increase the fruits or vegetables I eat each day to: (check one below)
___5 ___4 ___3 ___2 ___1



Decrease screen time (TV, movie, video games, cell phone, etc.) to: (check one below)
___2 hours ___2.5 hours ___3 hours ___3.5 hours



Increase exercise or physical activity everyday to: (check one below)
___1 hour ___45 minutes ___30 minutes ___15 minutes ___other

Decrease sugar sweetened drinks (soda, sports drinks, juice, etc.) to: (check one below)
___0 per day _____ 1 per week ___1 per day

how confident am I that I can accomplish my goal?

0 1 2 3 4 5 6 7 8 9 10

What might make it hard to achieve this goal? How might I overcome these barriers?

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