Name:	
Date:	

5210 AZ Way To Go!

Does anyone in your family have any of the following?

Diabetes	☐ Yes
High blood pressure	☐ Yes
Overweight	☐ Yes
Heart Disease *(heart attack, stroke, high cholesterol)*	☐ Yes

Healthy Habits Planning Tool

CIRCLE THE NUMBER THAT BEST DESCRIBES THE PATIENT'S LIFESTYLE CHOICES					
Servings per day of fruit and veggies	1	2	3	4	5+
Hours per day of screen time: TV, video games, computer or phone time	0	1	2	3	4+
Hours per day of play/exercise to the point of breathing hard	0	.5	1	2	3+
Days per week being active together as a family	0	1	2	3	4+
Glasses (8 oz.) per day of sugary drinks (juice, soda, sports drinks, energy drinks, flavored milk, lemonade, kool-aid, sweet tea/coffee)	0	1	2	3	4+
Meals per week together as a family at the table	0-1	2	3	4	5+
Days per week eating breakfast	0-1	2	3	4	5+
Hours per night sleeping	≤6	7	8	9	10+

WHAT IS ONE THING YOU WOULD LIKE TO CHANGE OR HELP YOUR CHILD CHANGE?

- ☐ Eat more fruits and vegetables
- ☐ Drink less sugary drinks
- ☐ Switch to low fat or fat free milk
- ☐ Drink more water
- ☐ Take the TV and/or computer out of the bedroom
- ☐ Eat less fast food / take-out
- ☐ Eat breakfast every day
- ☐ Spend less time in front of a screen
- ☐ Eat smaller portions
- ☐ Play outside more
- ☐ Eat together as a family more
- ☐ Be active as a family together more
- ☐ Get more hours of sleep a night

YOUR PERSONAL HEALTH GOAL _____

_____

_____

WE WILL MONITOR YOUR PROGRESS IN _____ WEEKS.

Patient/Guardian Signature: _____ Date: _____

Clinician Signature: _____ Date: _____