Rx to LiVe Well

MY NAME:_____ MY DOCTOR:_____ TODAY'S DATE::_____

WHERE I'M STARTING: Activity level: _____ minutes/week Weight:_____ pounds Sleep:_____ hours/day

MY KEY RISK AREAS AND POSSIBLE GOALS

Physical Activity

☐ **Moderate to vigorous aerobic physical activity:**
Brisk walking or _____
Days/week _____ x Minutes/day _____
= Total minutes per week: _____ (build up to at least 150)

☐ **Strength training** 2 or more days per week:
What: _____

☐ **Reduce total sitting time**
from _____ hours a day to _____ hours a day

☐ **Reduce screen time** (TV, video games, Internet)
from _____ hours a day to _____ hours a day

☐ **Other:** _____

Nutrition

☐ **Eat a healthy breakfast** _____ times per week

☐ **Eat or drink MORE of these:**
☐ fruits:_____servings/day ☐ vegetables: _____servings/day
☐ other: _____

☐ **Eat or drink LESS of these:**
☐ sweetened drinks - less than _____12-oz servings/**week**
☐ other: _____

☐ **Eat meals together** as a family_____ times per week

☐ **Keep a food journal** for_____days

☐ **Reduce portion sizes** by using a smaller plate or: _____

☐ **Other:** _____

Other Important Lifestyle Factors

☐ **Sleep** _____ hours per night _____ nights per week
(aim for 7 to 9 hours every night)

☐ **Manage stress** by: _____

☐ **Find a friend** or family member to support my commitment:
Who: _____

☐ **Reduce alcohol** intake to less than_____ drinks per week

☐ **Quit tobacco:** Method: _____Quit date: _____

☐ **Reward myself** for small changes and successes
How: _____

☐ **Other:** _____

Weight Management

☐ **Lose** _____**% of body weight or** _____ **pounds**
by_____(date)

☐ **Record weight** at least once per week for _____ weeks

☐ **Record food intake** every day for _____ days
☐ Target calories/day: _____ ☐ Target carb gms/day: ____

☐ **Record daily physical activity** for _____ weeks
Target minutes/week: ☐ 250 ☐ 300 ☐ Other: _____

☐ **Other:** _____

MAIN GOAL and PRESCRIPTION

Main goal my doctor and I agree on: _____

Patient education resources: ☐ Handouts given: _____

Referrals: ☐ Nutrition counseling: *Dietitian* _____ *Phone* _____
☐ Weigh to Health program: *Location* _____ *Phone* _____
☐ Other: _____

Tracking method: _____ ***Report or follow up:*** In _____ weeks / months with _____

Signed: _____(patient) _____(provider) _____(date)

Give the patient a copy of this Rx, and keep a copy in the patient's chart.

Pt Inst 50280

Intermountain® LiVe Well