MY ACTION PLAN
EVERYDAY CARE

I SHOULD TAKE THE FOLLOWING SUPPLEMENTS:

EACH MORNING	AT LUNCH	AT DINNER	AT BEDTIME

THESE SUPPLEMENTS SUPPORT MY:
(CHECK ALL THAT APPLY)

- ☐ HPA axis
- ☐ Metabolism
- ☐ Immune health
- ☐ Gastrointestinal system
- ☐ Cardiovascular health
- ☐ Musculoskeletal health
- ☐ General nutrition
- Other: _____

OTHER SUPPLEMENTS I TAKE:
(INCLUDE TIME OF DAY)

_____

AS NEEDED, I TAKE:

_____

MY TOP 3 OUTCOMES/GOALS

1. _____
2. _____
3. _____

WHAT'S MY FOOD FOCUS?
(CHECK ALL THAT APPLY)

- ☐ Elemental diet
- ☐ Elimination diet
- ☐ Gluten-free
- ☐ Dairy-free
- ☐ Unprocessed
- ☐ Low-carbohydrate
- ☐ Vegetarian
- ☐ High-protein
- ☐ Ketogenic
- Other _____

MOVING MY BODY
(CHECK ALL THAT APPLY)

- Continue with program ☐
- Be more mindful ☐
- Increase intensity ☐
- Increase duration ☐
- Schedule it ☐
- Get a buddy/ group ☐
- Other _____

I SHOULD MONITOR MY

☐ Sleep ☐ Energy ☐ Mood ☐ Bowel habits ☐ Foods I'm eating

☐ Comfort level Other:_____

YOUR NEEDS MAY CHANGE

If any of the following occur, contact your practitioner:
(CHECK ANY THAT APPLY AND CONTACT YOUR PRACTITIONER)

I changed my medications or supplements

I significantly changed my diet or exercise

I was diagnosed with a new condition or change in health status *(i.e. pregnancy, high blood pressure, etc.)*

MAXIMIZING YOUR PROGRAM

ONLINE RESOURCES:	COMMUNITY RESOURCES:	OTHER PRACTITIONERS:

IF I AM UNSURE OF WHAT TO DO, I SHOULD:

CONTACT MY PRACTITIONER:

[practice name] _____ [contact name] _____

[phone number] _____ [email address] _____

Call 911 if it is a medical emergency