

# 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)

<input type="checkbox"/> HPA axis	<input type="checkbox"/> Metabolism	<input type="checkbox"/> Immune health
<input type="checkbox"/> Gastrointestinal system	<input type="checkbox"/> Cardiovascular health	<input type="checkbox"/> Musculoskeletal health
<input type="checkbox"/> 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:

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COMMUNITY RESOURCES:

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OTHER PRACTITIONERS:

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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