Diabetes Self Care Goal Sheet

❑ Eat ___ serving of fruit and vegetables

❑ Walk ___ minutes a day

❑ Take my medicine on time

❑ Test my blood sugar ___ times

❑ Lose ___ pounds

❑ Have an annual eye exam

❑ Check my feet daily

❑ Stop smoking

❑ Other goal ___

❑ Stop or limit my alcohol

Choose one goal at a time.

What will I do? _____

When will I do it? _____

Where would I do it? _____

How often will I do it? _____

What might get in the way of my plan? _____

What could I do to make sure my plan works? _____

Goal review

How important is this goal to you? (rate 1–10) Circle one

1	2	3	4	5	6	7	8	9	10
Not at all		A little		Somewhat sure		Very sure			Totally sure

How sure are you that you will reach this goal? (rate 1–10) Circle one

1	2	3	4	5	6	7	8	9	10
Not at all		A little		Somewhat sure		Very sure			Totally sure

Patient Signature: _____ Clinician Signature: _____ Date_____

Agreed upon by the patient and clinician