# PATIENT-CENTERED CARE PLAN

Patient name:_____ Date:_____
DOB:_____

Provider name:_____

Please complete all sections prior to your visit
The main things I would like to fix or improve about my health are:
•
•
The main things preventing me from improving my health are:
•
The main symptoms I wish to reduce or eliminate are:
•
List any other providers you see regularly for health care (for example, ophthalmologist, cardiologist, therapist):
•
•
•
Resources and supports
Besides your health care team, who could you turn to for help for health-related problems (for example, family members, friends, a spiritual leader)?
•
My medications
I agree to take the medication prescribed, discuss any problems I may have, and advise my primary care provider (PCP) of any changes to this list
_____
_____
_____
_____
_____

My allergies
_____ _____

My problems (to be done by medical staff)
_____
_____

Family History
_____
_____

Treatment goals/targets
Please initial the goals that you would like to do to improve your health and provide comments:
_____ Complete test/labs the doctor has ordered
_____ See other doctors and health care providers
_____ Use community resources
_____ Make no changes to my medication without discussing with my provider
_____ Pursue health-related education
_____ Pursue new activities
_____ Monitor/transmit my measures of health data ( B/P, Pulse, Weight, Blood Sugar )
_____ Answer behavioral questionnaires as needed.

Lifestyle changes:
_____ Diet
_____ Exercise
_____ Stress management
_____ Safety
_____ Stop smoking
_____ Stop bad habits
If I follow the treatment/action plan above, I can expect the following to happen:

I have reviewed the above information and it is correct with any changes I have made. If I need help arranging care outside this office or have questions or concerns, I understand that I can contact the office.

Patient Signature: _____