Asthma self-management goals

for children 10 years and older

Patient name _____

Date of birth _____

Daytime phone # _____

Address _____

City/State/Zip _____

Today's date _____

Follow up time frame:

_____

_____

_____

_____

Goal setting

1. Choose an activity goal below:

❑ I will know my (check all that apply):
- ❑ Early asthma warning signs
- ❑ Green, yellow, and red peak flow zones
- ❑ Red flags

❑ I will follow my action plan and take my medicines.

❑ I will learn asthma triggers and how to prevent them.

❑ I will help my child know how to use (check all that apply):
❑ Spacer ❑ Belly breathing ❑ Peak flow meter

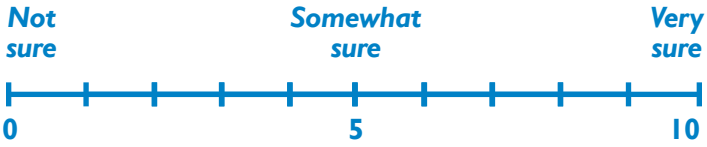
Protect asthmatic children in the home

❑ Reduce asthma triggers in your home
- ❑ Dust mites ❑ Strong odors
- ❑ Smokers ❑ Mold
- ❑ Cockroaches ❑ Animal dander

❑ If I smoke:
- ❑ I'll ask my doctor how to quit smoking
- ❑ I'll smoke _____ less cigarettes per day
- ❑ I'll set a date to quit smoking
- ❑ I'll eliminate secondhand smoke

2. Choose your confidence level:

I think I can succeed at this goal:



3. Fill in the following for your chosen goal:

What: _____

_____

_____

When: _____

_____

_____

How much: _____

_____

_____

How often: _____

_____

_____

Barriers to meeting goal: _____

_____

_____

_____

Clinician signature

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