



# Asthma self-management goals






for children up to nine years old

Patient name \_\_\_\_\_  
 Date of birth \_\_\_\_\_  
 Daytime phone # \_\_\_\_\_  
 Address \_\_\_\_\_  
 City/State/Zip \_\_\_\_\_  
 Today's date \_\_\_\_\_

Follow up time frame:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

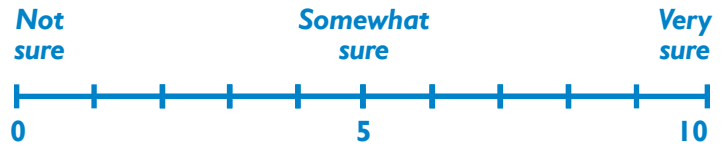
## Goal setting

### 1. Choose an activity goal below:

-   I will learn how to tell when my child's asthma is getting worse and call the doctor.
- I will know my child's (check all that apply):
  - Early asthma warning signs
  - Green, yellow, and red peak flow zones
  - Red flags
-   I will help my child follow their action plan and take all their 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