My Action Plan for Mental Health

Instructions: Fill in as much of this form as you can. Ask your doctor or therapist if she or he would please fill in the parts you can't finish.

My name: Date:

My address:

Name of my doctor or clinic:

Phone number of my doctor or clinic:

Who to contact for me in case of an emergency:

(Name) (Phone number)

Your Healthcare Plus phone number : 1-800-973-6792

Illinois Nurse Consultation Line phone number (to call when my doctor's office is closed): to come

I should contact the doctor if I:

- ❑ Have more trouble sleeping than usual
- ❑ Feel or act more angry than usual
- ❑ Feel restless or can't settle down
- ❑ Feel or act more depressed than usual or am in a 'down' mood for a long time
- ❑ Have new trouble with everyday activities
- ❑ Feel more tense or anxious or afraid
- ❑ Have a hard time concentrating
- ❑ Am eating more or less than usual
- ❑ Feel or act confused or have a hard time thinking straight

What are the names of my medicines?	How much medicine do I take each time?	How often do I take each medicine?	What is the best time of day to take each medicine?

Your Healthcare Plus™

Extra help for better health

a free benefit of

ILLINOIS DEPARTMENT OF Healthcare and Family Services

©2006 McKesson Health Solutions LLC.
Your Healthcare Plus™ is a trademark of the State of Illinois.
Printed by authority of the State of Illinois.
ILMIEN0706_68306 5000

I should contact my doctor if I:

- ❑ Feel like I am having side effects or am getting sick from my medicine.
- ❑ Feel like I am going to stop taking my medicines.
- ❑ Feel like I want to harm myself or others.

Other things I can do to feel better and have more energy:

Exercise _____ times a week for _____ minutes each time

Eat foods that are healthy including:

- ❑ Fish (like salmon) that have omega fatty acid _____ time(s) each week
- ❑ Vegetables (these are a good source of vitamins, minerals and fiber) _____ times each day
- ❑ Fruits (these are a good source of fiber, especially if I leave the skin on the fruit) _____ times each day
- ❑ Low fat dairy products such as _____, _____, _____ times each day
- ❑ Whole grain foods such as _____, _____, _____ times each day

I will not drink coffee, cola drinks or other drinks with caffeine more than _____ times each day

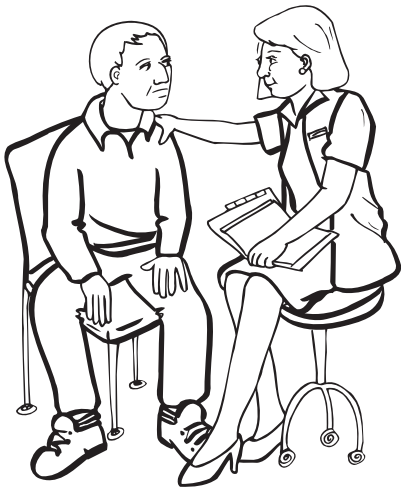
Foods to eat less of or stay away from are: _____

_____

_____

My doctor says I should weigh _____ pounds

My doctor says I should try to hit this goal by _____ (date)



I will contact my doctor for help to stop smoking.

Get started in a "quit smoking" program by: _____ (date)

I should get a flu shot every fall. ❑ Yes ❑ No

Numbers I should know

LDL (bad) cholesterol _____ ❑ Yes ❑ No

Hemoglobin A1c (if I have diabetes) _____ ❑ Yes ❑ No

Blood pressure _____ ❑ Yes ❑ No

I should see my therapist _____ times each year.

I see my therapist on these days: _____

I should see my medical doctor _____ times each year.

My next medical appointment is on: _____ (date)