Personal Wellness Plan

PATIENT INFORMATION

Name: _____ Age: _____

Gender: _____ Contact Number: _____

Email Address: _____

HEALTH ASSESSMENT

Weight: _____ Height: _____

BMI: _____ Blood Pressure: _____

Other Health Data

WELLNESS GOALS

Short-Term Goal

Long-Term Goal

PHYSICAL HEALTH PLAN

Exercise Routine

Dietary Changes

Sleep Schedule

MENTAL HEALTH PLAN

Stress Management

Mindfulness Activities

Therapy Sessions

EMOTIONAL WELL-BEING

Self-Care Activities

Social Support

Hobbies/Interests

LIFESTYLE ADJUSTMENTS

Work-Life Balance

Time Management

Other Changes

PROGRESS TRACKING

Follow-up Appointments

Wellness Journal

Health Metrics

DOCTOR'S SIGNATURE

Name: _____ Date: _____ dd / mm / yyyy