


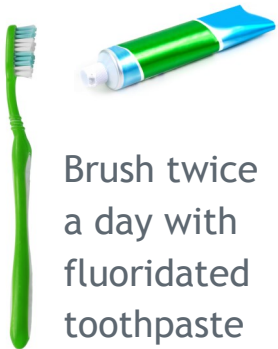








My Self Management Goal Sheet

Patient Name: _____

Date: _____

Check the box of the goal or goals you want to work on now. We suggest 1-2 goals.

<input type="checkbox"/>  <p>Get regular dental care</p>	<input type="checkbox"/>  <p>Brush twice a day with fluoridated toothpaste</p>	<input type="checkbox"/>  <p>Floss once a day AM or PM?</p>	<input type="checkbox"/>  <p>Drink tap water, with and in-between meals</p>
<input type="checkbox"/>  <p>Use a fluoridated, non-alcoholic mouth rinse</p>	<input type="checkbox"/>  <p>Be tobacco and alcohol-free</p>	<input type="checkbox"/>  <p>Choose snacks low in sugar like nuts, dairy, fruits, and vegetables</p>	<input type="checkbox"/>  <p>Other goal for a healthy mouth</p>

When will I do this? _____

How often will I do this? _____



My confidence level that I can complete this goal

1 2 3 4 5 6 7 8 9 10



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