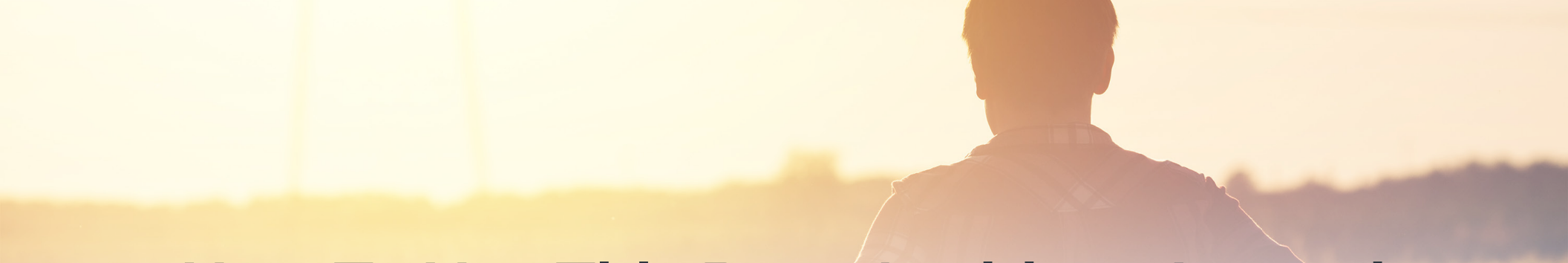

How To Use This Post-Accident Journal

How has your life changed since your accident?

So much happens after an accident that remembering it all is impossible. What's more, the shock, grief and adrenaline that often occurs following a serious injury can make memories of the event fade or warp over time.

Since insurance claims and lawsuits operate on facts, it is important that even the smallest details surrounding an accident or injury are preserved. This will help build a stronger case for compensation later on, and it will take the stress off of you so that you can focus on healing.

Use this worksheet so that you don't forget any important details from your accident and post-accident recovery. Keep at it every day, and don't give up!

DAILY POST-ACCIDENT JOURNAL

Date: _____

How are you feeling today?
(circle your pain rating)

1-2
No pain

3-4
Mild pain

5-6
Moderate pain

7-8
Severe pain

9-10
Extreme pain

Location of the pain: _____

Describe your symptoms and how you're feeling

What activities caused pain, or what activities did you miss because of your injury?

How long did the pain last, or how frequently were you in pain?

Did you take any medications or treatment?

NOTES:

WEEKLY POST-ACCIDENT JOURNAL

Week of (date): _____


1-2
No pain


3-4
Mild


5-6
Moderate


7-8
Severe pain


9-10
Extreme

Date and time	Location of pain	Symptoms	Severity 1 - 10	Trigger (when you noticed it)	Drug and/or treatments used	Notes

MONTHLY POST-ACCIDENT JOURNAL

Month and year: _____


1-2
No pain


3-4
Mild


5-6
Moderate


7-8
Severe pain


9-10
Extreme

Type/location of pain	Days of the month																													
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Head																															
Headache/migraine																															
Neck																															
Back (upper)																															
Back (middle)																															
Back (lower)																															
Collarbone																															
Shoulder																															
Elbow																															
Wrist																															
Hand																															
Chest																															
Torso/ribs																															
Hip																															
Tailbone																															
Knee																															
Ankle																															
Foot																															
Muscles																															
Numbness																															
Stiffness																															
Tingling																															
Fatigue																															
Nausea																															
Bruising																															
Burns																															

DAILY MEDICATION

Journal

Week of (date) _____

Weekday	Medication	Time	Dose	With Food Circle Y / N	Side Effects	Time Noticed	Notes
Monday				Y N Y N Y N Y N			
Tuesday				Y N Y N Y N Y N			
Wednesday				Y N Y N Y N Y N			
Thursday				Y N Y N Y N Y N			
Friday				Y N Y N Y N Y N			
Saturday				Y N Y N Y N Y N			
Sunday				Y N Y N Y N Y N			

Be sure to include any medications including OTC, prescription, vitamins and supplements.

DAILY SYMPTOMS

Week of (date)

Medications/therapies

Activities affected

Able to work? Give details.

Symptoms and how you're feeling

Duration/frequency

Insurance communications and medical treatments

(organization name, name of person, what they said, duration of visit/conversation)