# POST-ACCIDENT JOURNAL

## Document how your life has changed since your accident

## FORMS INCLUDED

Overview of Pain and Symptoms

Weekly Journal

Daily Journal

## GUIDELINES

Begin writing down any details as soon as you can after your accident.

Make an entry whenever you have something to report. This may be daily in the beginning or weekly as you begin to reach maximum medical improvement.

Remember: this diary may be examined by others as part of your case. Strive for detailed, accurate, brief yet complete descriptions.

## SUGGESTED USE

Start a binder to organize documents relating to your accident.

Print this entire document once. Add to your binder.

Make copies of the weekly or daily log page, depending on how detailed you think you can be.

Keep the log pages where you will remember to fill them out. It may be helpful to fill it out at the same time every day. If you don't keep them in your binder, add them as you complete them.

You may wish to provide the first page below "Overview of Pain and Symptoms Resulting from my Accident" to your doctor for inclusion in your medical records.


See Enjuris.com/pdf/ for other documents you might find useful.

# DAILY POST-ACCIDENT

## Journal

Name: _____ Date: _____

Symptoms and How You're Feeling

Activities Affected

Duration/Frequency

Medications/Therapies and Side Effects

Able to work? Give details.

Insurance communications and medical treatments (organization name, name of person, what they said, duration of visit/conversation)

# WEEKLY POST-ACCIDENT

## Journal

Name: _____ Week of (date): _____

| Day | Symptoms and Details | Severity 1-10 | Trigger (when noticed it) | Medications/therapies and side effects | Activities affected | Able to work? (give details, examples) | Insurance communications and medical visits (add details in daily journal) |
|---|---|---|---|---|---|---|---|
| Sunday | | | | | | | |
| Monday | | | | | | | |
| Tuesday | | | | | | | |
| Wednesday | | | | | | | |
| Thursday | | | | | | | |
| Friday | | | | | | | |
| Saturday | | | | | | | |

# OVERVIEW OF PAIN AND SYMPTOMS

## Resulting from My Accident

Name

Date

This form is to be supported with daily and weekly documentation in your journal on the previous pages.

| **Symptoms**<br>E.g., pain, sleeplessness, stiffness, reduced mobility, nausea, anxiety, etc. | **Details**<br>E.g., sharp pain in neck, difficulty falling asleep, hands shaking, etc. | **Severity**<br>**1-10**<br>(minimal - worst) | **First Noticed**<br>Include dates | **Activities Affected**<br>E.g., can't drive, missed work, can't lift granddaughter, reduced concentration, difficult to look over shoulder when driving, etc. | **Timing**<br>Duration/frequency, e.g., 1-3 hours, every day, mornings, after lying down etc. |
|---|---|---|---|---|---|
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |
| 4. | | | | | |
| 5. | | | | | |

What medication/therapies do you use?

What side effects have you noticed?