

# 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/](https://enjuris.com/pdf/) for other documents you might find useful.

# DAILY POST-ACCIDENT Journal

Name: \_\_\_\_\_ Date: \_\_\_\_\_



Symptoms and How You're Feeling

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Activities Affected

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Duration/Frequency

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Medications/Therapies and Side Effects

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Able to work? Give details.

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

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# 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 E.g., pain, sleeplessness, stiffness, reduced mobility, nausea, anxiety, etc.	Details E.g., sharp pain in neck, difficulty falling asleep, hands shaking, etc.	Severity 1-10 (minimal - worst)	First Noticed Include dates	Activities Affected E.g., can't drive, missed work, can't lift granddaughter, reduced concentration, difficult to look over shoulder when driving, etc.	Timing 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?

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What side effects have you noticed?

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