DAILY MEDICAL & PAIN JOURNAL

HOW TO USE THIS JOURNAL

Use this journal to keep a daily record of how your injury affects you. Record your symptoms, medical appointments, treatment, medications, activities you could or could not perform, and other changes you notice.

Be honest and specific. Do not exaggerate or minimize your symptoms.

IMPORTANT: This journal is a personal record and is not a substitute for medical advice or treatment. Follow the instructions of your healthcare provider and seek appropriate medical care for your injuries.

IMPORTANT NOTICE: This journal is provided for personal recordkeeping purposes only. It does not provide medical or legal advice and does not replace evaluation or treatment by a qualified healthcare professional.

DAILY ENTRY

Date: _____ **Day:** _____

1. OVERALL PAIN LEVEL

0	1-3	4-6	7-9	10
No Pain	Mild	Moderate	Severe	Worst Pain

Pain Level Today: _____ / 10

2. WHERE DID YOU EXPERIENCE PAIN OR DISCOMFORT?

- ☐ Head
- ☐ Neck
- ☐ Shoulder
- ☐ Back
- ☐ Arm
- ☐ Hand
- ☐ Hip
- ☐ Leg
- ☐ Knee
- ☐ Foot
- ☐ Other: _____

3. SYMPTOMS EXPERIENCED

- ☐ Pain
- ☐ Swelling
- ☐ Stiffness
- ☐ Numbness
- ☐ Tingling
- ☐ Weakness
- ☐ Headache
- ☐ Dizziness
- ☐ Difficulty sleeping
- ☐ Other: _____

4. DESCRIBE YOUR SYMPTOMS

What symptoms did you experience today? When did they occur? What made them better or worse?

5. MEDICAL TREATMENT TODAY

Doctor/Provider: _____ **Time:** _____

Type of Appt/Treatment: _____ **Notes/Instructions:** _____

6. MEDICATION

Medication	Time Taken	Reason	Notes

7. DAILY ACTIVITIES AFFECTED

- ☐ Walking
- ☐ Standing
- ☐ Sitting
- ☐ Driving
- ☐ Working
- ☐ Sleeping
- ☐ Exercising
- ☐ Household chores
- ☐ Personal care
- ☐ Shopping
- ☐ Childcare
- ☐ Other: _____

8. WHAT COULD YOU NOT DO TODAY BECAUSE OF YOUR INJURY?

9. WORK & INCOME IMPACT

Did your injury affect your ability to work? ☐ Yes ☐ No

Hours missed: _____ **Other impact:** _____

10. ADDITIONAL NOTES

WEEKLY INJURY & RECOVERY SUMMARY

Week of: _____ **Number of Medical Appointments:** _____

Average Pain Level: _____ **Work Days/Hrs Missed:** _____

Highest Pain Level: _____

SYMPTOMS THIS WEEK

TREATMENT RECEIVED

ACTIVITIES I COULD NOT PERFORM

CHANGES SINCE LAST WEEK

QUESTIONS FOR MY HEALTHCARE PROVIDER