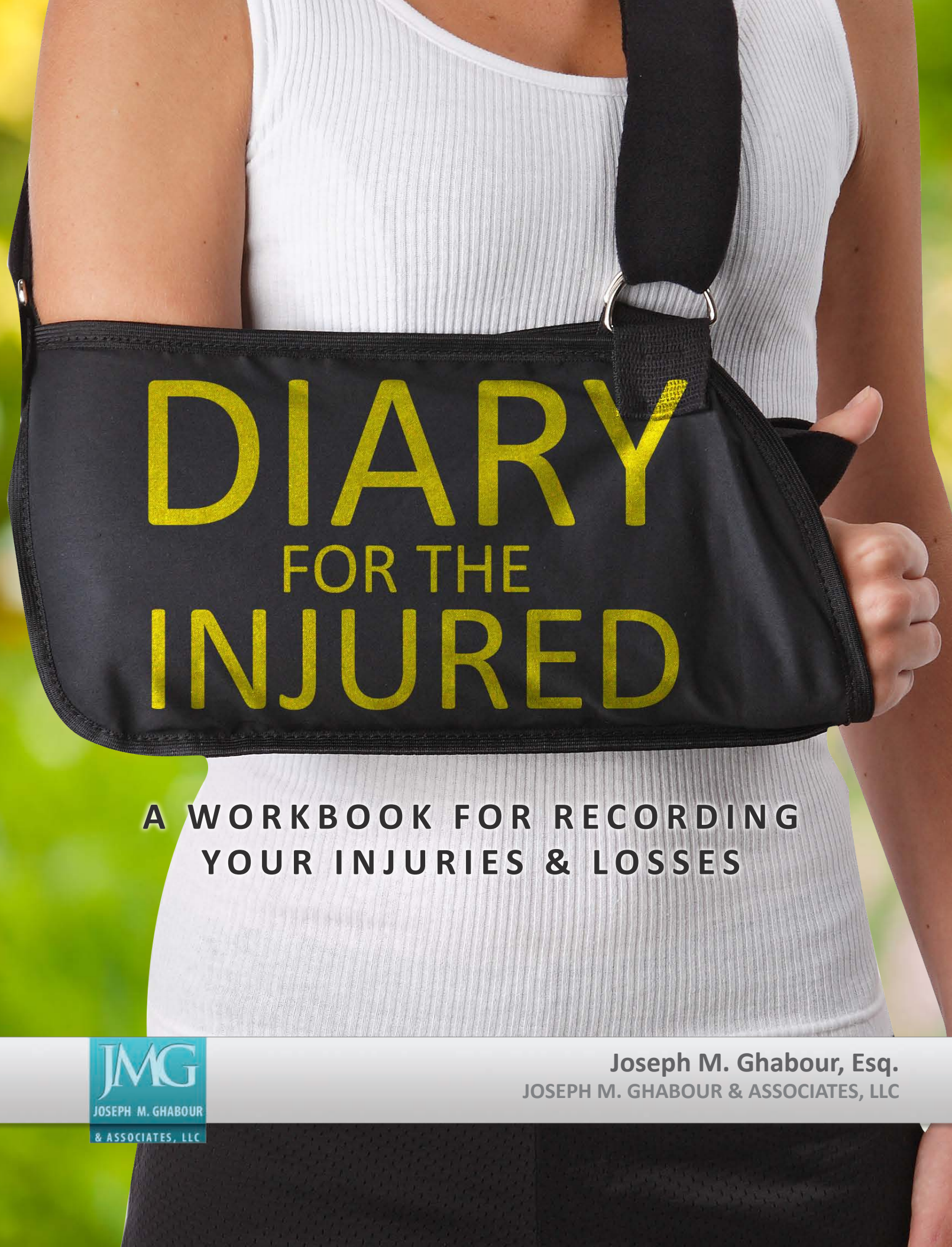

A WORKBOOK FOR RECORDING YOUR INJURIES & LOSSES

JMG
JOSEPH M. GHABOUR
& ASSOCIATES, LLC

Joseph M. Ghabour, Esq.
JOSEPH M. GHABOUR & ASSOCIATES, LLC

DIARY
FOR THE
INJURED

A WORKBOOK FOR RECORDING YOUR INJURIES & LOSES

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Word Association Publishers
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Diary for the Injured

A Workbook for Recording Your Injuries & Losses

When it comes to receiving fair compensation from insurance companies, documentation is everything. That's why I created *Diary for the Injured*. I wanted to provide an easy-to-use tool to help you, your doctor and your attorney ensure that the facts of your accident and the full extent of your injuries are understood and well documented.

Your memory of the accident is a valuable source of information, but it becomes less and less reliable as time passes and important details can be forgotten. So, as soon as you can after the accident, sit down and fill out the "Accident Record" section.

Both you and your doctor are responsible for documenting your injuries, but each of you has a different job to do. Your job is to record the ways in which your injuries impact you from a personal perspective: the pain you feel, the activities in which you can no longer engage and any other ways in which the injuries have impacted your life.

To that end, I've also included the "Documenting Your Injuries" section. It contains both specific questions regarding your symptoms and a convenient format for tracking them over the course of several months.

By taking these steps—writing an account of your accident and tracking your symptoms during your recovery—you are doing yourself a tremendous favor: you are helping to ensure that you will be able to obtain the financial resources you need to fully recovery.

Accident Record

Other Driver

Name: _____

Address: _____

_____

Home Phone #: _____

Work Phone #: _____

Driver's License #: _____

Date of Birth: _____

Other Vehicle

Make/Model: _____

Year: _____

License #: _____

Vehicle ID #: _____

Damage Location: _____

_____

Owner's Name: _____

Address: _____

_____

Phone #: _____

Insurance Co.: _____

Policy #: _____

Police Officer

Name: _____
Department: _____
Badge #: _____
Police Report #: _____

Passengers
(other vehicle)

Name: _____
Age: _____
Address: _____

_____
Phone #: _____

Name: _____
Age: _____
Address: _____

_____
Phone #: _____

Name: _____
Age: _____
Address: _____

_____
Phone #: _____

Name: _____
Age: _____
Address: _____

_____
Phone #: _____

Witnesses

Name: _____

Address: _____

_____

Phone #: _____

What they saw: _____

_____

_____

Name: _____

Address: _____

_____

Phone #: _____

What they saw: _____

_____

_____

Name: _____

Address: _____

_____

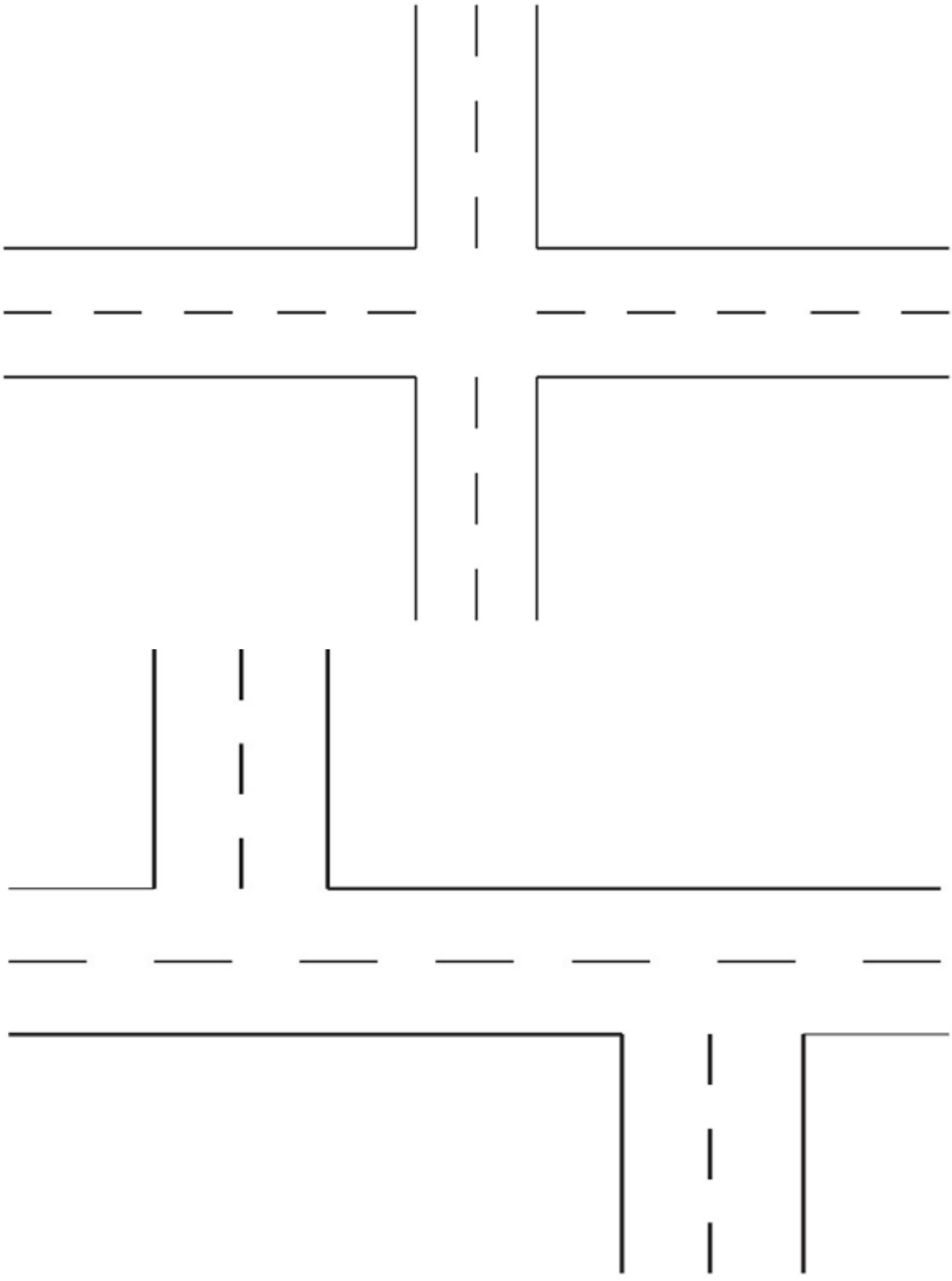
Phone #: _____

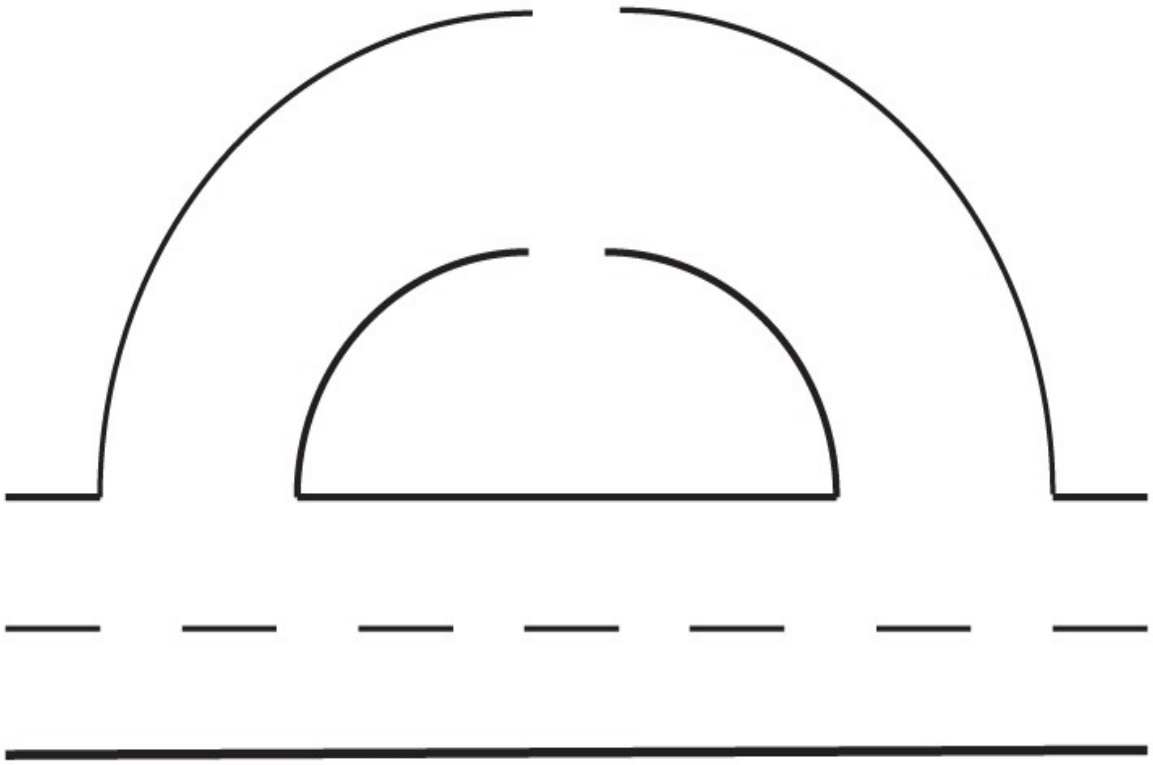
What they saw: _____

_____

_____

Draw the positions of both cars before, during and after the accident. Include traffic signs, stop lights and street lights. Use arrows to indicate direction of travel for all cars.





Date of Accident: _____

Time of Accident: _____

Weather Conditions: _____

_____

Road Conditions: _____

_____

Location: _____

_____

How the Accident Occurred: _____

_____

_____

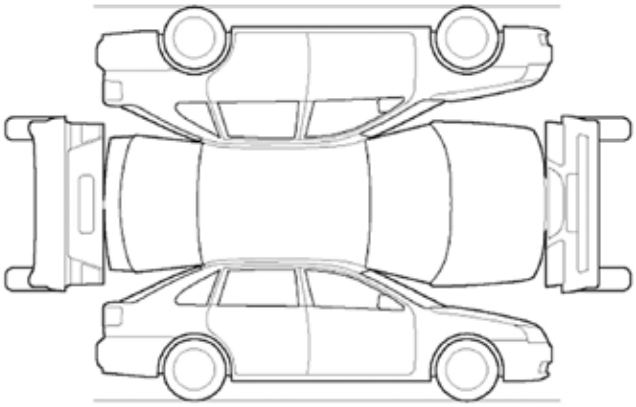
_____

_____

_____

Damage to My Car

Draw any damage to your car in the diagram below. Indicate the damage by placing an X where appropriate.

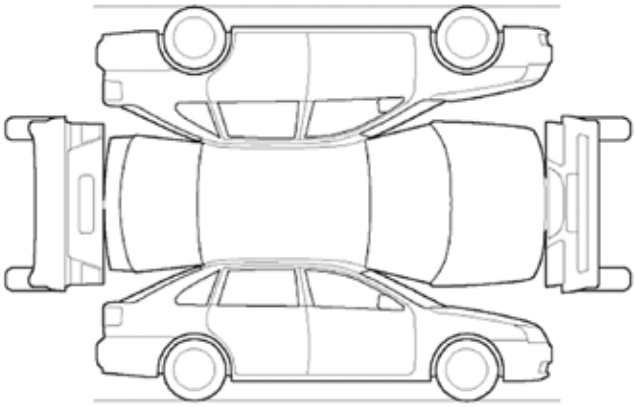


Description of damage: _____

_____

Damage to the Other Car

Draw any damage to the other car in the diagram below. Indicate the damage by placing an X where appropriate.



Description of damage: _____

_____

My Injuries

_____

_____

_____

_____

Taken by ambulance? Yes ____ No ____

Hospital: _____

Others Injured

Name: _____

Injuries: _____

_____

Taken by ambulance? Yes _____ No _____

Hospital: _____

Name: _____

Injuries: _____

_____

Taken by ambulance? Yes _____ No _____

Hospital: _____

Name: _____

Injuries: _____

_____

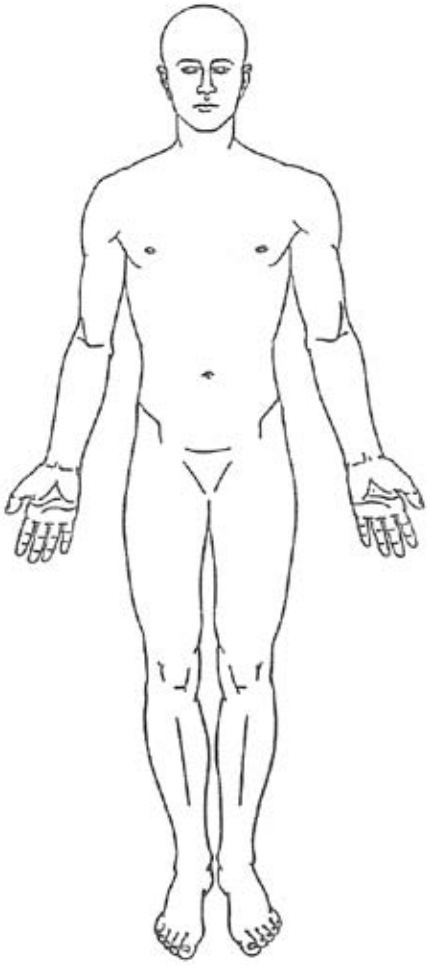
Taken by ambulance? Yes _____ No _____

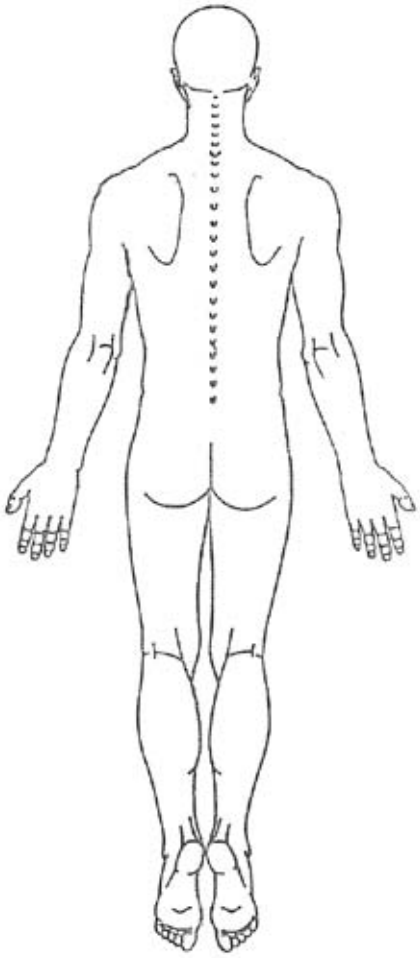
Hospital: _____

Documenting Your Injuries

Locations of Pain

Please use the diagrams below to indicate the locations of your injuries.





Neck Pain **Yes____** **No ____**

Severity: Please rate the intensity of your pain on a scale from one to ten (one being barely noticeable, ten being extreme).

1 2 3 4 5 6 7 8 9 10

Fluctuation: Is the pain consistent or does it fluctuate? _____

_____

Triggers: When does it hurt most? Are there activities that can cause pain? _____

_____

Improvement: Is your pain getting better or worse? _____

_____

Right Shoulder Pain **Yes____** **No ____**

Severity: Please rate the intensity of your pain on a scale from one to ten (one being barely noticeable, ten being extreme).

1 2 3 4 5 6 7 8 9 10

Fluctuation: Is the pain consistent or does it fluctuate? _____

_____

Triggers: When does it hurt most? Are there activities that can cause pain? _____

_____

Improvement: Is your pain getting better or worse? _____

_____

Left Shoulder Pain **Yes____** **No ____**

Severity: Please rate the intensity of your pain on a scale from one to ten (one being barely noticeable, ten being extreme).

1 2 3 4 5 6 7 8 9 10

Fluctuation: Is the pain consistent or does it fluctuate? _____

_____

Triggers: When does it hurt most? Are there activities that can cause pain? _____

_____

Improvement: Is your pain getting better or worse? _____

_____

Right Arm Pain **Yes____** **No ____**

Severity: Please rate the intensity of your pain on a scale from one to ten (one being barely noticeable, ten being extreme).

1 2 3 4 5 6 7 8 9 10

Fluctuation: Is the pain consistent or does it fluctuate? _____

_____

Triggers: When does it hurt most? Are there activities that can cause pain? _____

_____

Improvement: Is your pain getting better or worse? _____

_____

Left Arm Pain **Yes____** **No ____**

Severity: Please rate the intensity of your pain on a scale from one to ten (one being barely noticeable, ten being extreme).

1 2 3 4 5 6 7 8 9 10

Fluctuation: Is the pain consistent or does it fluctuate? _____

_____

Triggers: When does it hurt most? Are there activities that can cause pain? _____

_____

Improvement: Is your pain getting better or worse? _____

_____

Mid Back Pain **Yes____** **No ____**

Severity: Please rate the intensity of your pain on a scale from one to ten (one being barely noticeable, ten being extreme).

1 2 3 4 5 6 7 8 9 10

Fluctuation: Is the pain consistent or does it fluctuate? _____

_____

Triggers: When does it hurt most? Are there activities that can cause pain? _____

_____

Improvement: Is your pain getting better or worse? _____

_____

Low Back Pain **Yes____** **No ____**

Severity: Please rate the intensity of your pain on a scale from one to ten (one being barely noticeable, ten being extreme).

1 2 3 4 5 6 7 8 9 10

Fluctuation: Is the pain consistent or does it fluctuate? _____

_____

Triggers: When does it hurt most? Are there activities that can cause pain? _____

_____

Improvement: Is your pain getting better or worse? _____

_____

Right Knee Pain **Yes____** **No ____**

Severity: Please rate the intensity of your pain on a scale from one to ten (one being barely noticeable, ten being extreme).

1 2 3 4 5 6 7 8 9 10

Fluctuation: Is the pain consistent or does it fluctuate? _____

_____

Triggers: When does it hurt most? Are there activities that can cause pain? _____

_____

Improvement: Is your pain getting better or worse? _____

_____

Left Knee Pain **Yes____** **No ____**

Severity: Please rate the intensity of your pain on a scale from one to ten (one being barely noticeable, ten being extreme).

1 2 3 4 5 6 7 8 9 10

Fluctuation: Is the pain consistent or does it fluctuate? _____

_____

Triggers: When does it hurt most? Are there activities that can cause pain? _____

_____

Improvement: Is your pain getting better or worse? _____

_____

Right Ankle Pain **Yes____** **No ____**

Severity: Please rate the intensity of your pain on a scale from one to ten (one being barely noticeable, ten being extreme).

1 2 3 4 5 6 7 8 9 10

Fluctuation: Is the pain consistent or does it fluctuate? _____

_____

Triggers: When does it hurt most? Are there activities that can cause pain? _____

_____

Improvement: Is your pain getting better or worse? _____

_____

Left Ankle Pain **Yes____** **No ____**

Severity: Please rate the intensity of your pain on a scale from one to ten (one being barely noticeable, ten being extreme).

1 2 3 4 5 6 7 8 9 10

Fluctuation: Is the pain consistent or does it fluctuate? _____

_____

Triggers: When does it hurt most? Are there activities that can cause pain? _____

_____

Improvement: Is your pain getting better or worse? _____

_____

Headaches **Yes____** **No ____**

Severity: Please rate the intensity of your pain on a scale from one to ten (one being barely noticeable, ten being extreme).

1 2 3 4 5 6 7 8 9 10

Fluctuation: Is the pain consistent or does it fluctuate? _____

_____

Triggers: When does it hurt most? Are there activities that can cause pain? _____

_____

Improvement: Is your pain getting better or worse? _____

_____

Psychological/Neurological Symptoms

Please rate the frequency with which you experience the following symptoms. (Circle one.)

Difficulty concentrating	*constantly*	*frequently*	*occasionally*	*never*
Memory gaps	*constantly*	*frequently*	*occasionally*	*never*
Disorientation	*constantly*	*frequently*	*occasionally*	*never*
Dizziness	*constantly*	*frequently*	*occasionally*	*never*
Insomnia	*constantly*	*frequently*	*occasionally*	*never*
Oversleeping	*constantly*	*frequently*	*occasionally*	*never*
Lethargy/Chronic fatigue	*constantly*	*frequently*	*occasionally*	*never*
Anxiety/Depression	*constantly*	*frequently*	*occasionally*	*never*
Nausea/Vomiting	*constantly*	*frequently*	*occasionally*	*never*
Hypersensitivity to light/sound	*constantly*	*frequently*	*occasionally*	*never*
Irritability	*constantly*	*frequently*	*occasionally*	*never*

Pain Intensity and General Disability

Please rate each of the following on a scale from one to ten (one being barely noticeable, ten being extreme).

Overall pain intensity

1 2 3 4 5 6 7 8 9 10

Interruption of sleep pattern due to pain

1 2 3 4 5 6 7 8 9 10

Interruption of social or physical activities (dancing, exercising, etc.) due to pain

1 2 3 4 5 6 7 8 9 10

Interruption of personal care (showering, dressing, etc.) due to pain

1 2 3 4 5 6 7 8 9 10

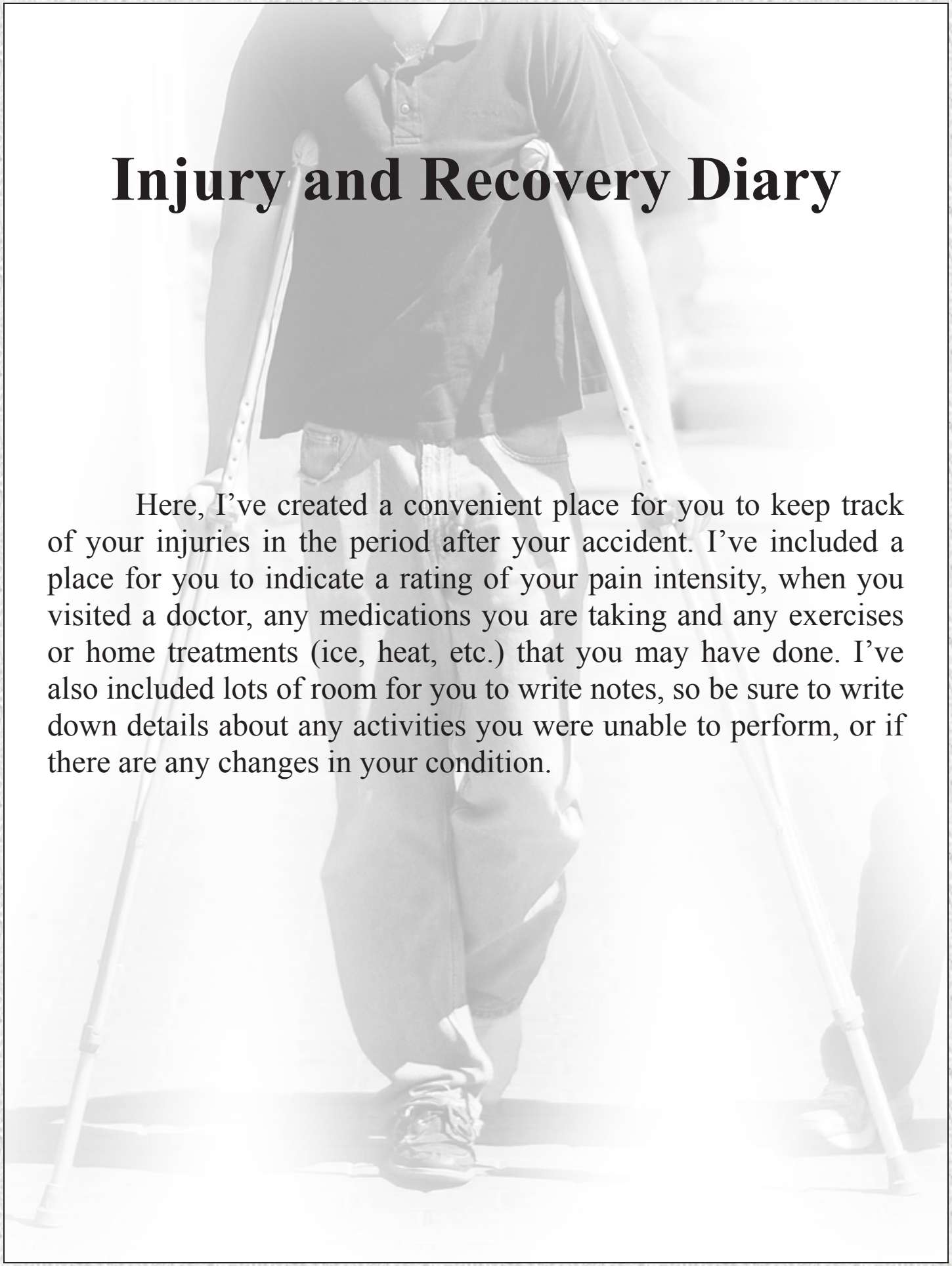
Interruption of housework (dishwashing, laundry, yard work, etc.) due to pain

1 2 3 4 5 6 7 8 9 10

Are you unable to perform the following?

Please circle one to indicate how often your pain **prevents or interferes with** performance of the following everyday activities.

Normal work duties	*Always*	*Frequently*	*Occasionally*	*Never*
Lifting	*Always*	*Frequently*	*Occasionally*	*Never*
Sitting	*Always*	*Frequently*	*Occasionally*	*Never*
Standing	*Always*	*Frequently*	*Occasionally*	*Never*
Walking	*Always*	*Frequently*	*Occasionally*	*Never*
Reading	*Always*	*Frequently*	*Occasionally*	*Never*
Driving	*Always*	*Frequently*	*Occasionally*	*Never*
Concentrating	*Always*	*Frequently*	*Occasionally*	*Never*



Injury and Recovery Diary

Here, I've created a convenient place for you to keep track of your injuries in the period after your accident. I've included a place for you to indicate a rating of your pain intensity, when you visited a doctor, any medications you are taking and any exercises or home treatments (ice, heat, etc.) that you may have done. I've also included lots of room for you to write notes, so be sure to write down details about any activities you were unable to perform, or if there are any changes in your condition.

Week 1

Date(s): _____

Average pain intensity rating (1-10):
1 2 3 4 5 6 7 8 9 10

Medical Appointments (circle day(s) of the week):
M T W Th F Sat Sun

Type of Doctor (circle those that apply):
MD DC DO PT Acupuncturist

Describe treatment provided: _____
_____

Medications taken: _____
_____

Home treatments/exercises administered: _____
_____
_____

Progress of Recovery/Notes on Symptoms: _____
_____
_____
_____
_____
_____

Week 2

Date(s): _____

Average pain intensity rating (1-10):
1 2 3 4 5 6 7 8 9 10

Medical Appointments (circle day(s) of the week):
M T W Th F Sat Sun

Type of Doctor (circle those that apply):
MD DC DO PT Acupuncturist

Describe treatment provided: _____
_____

Medications taken: _____
_____

Home treatments/exercises administered: _____
_____
_____

Progress of Recovery/Notes on Symptoms: _____
_____
_____
_____
_____
_____

Week 3

Date(s): _____

Average pain intensity rating (1-10):
1 2 3 4 5 6 7 8 9 10

Medical Appointments (circle day(s) of the week):
M T W Th F Sat Sun

Type of Doctor (circle those that apply):
MD DC DO PT Acupuncturist

Describe treatment provided: _____
_____

Medications taken: _____
_____

Home treatments/exercises administered: _____
_____
_____

Progress of Recovery/Notes on Symptoms: _____
_____
_____
_____
_____
_____

Week 4

Date(s): _____

Average pain intensity rating (1-10):
1 2 3 4 5 6 7 8 9 10

Medical Appointments (circle day(s) of the week):
M T W Th F Sat Sun

Type of Doctor (circle those that apply):
MD DC DO PT Acupuncturist

Describe treatment provided: _____
_____

Medications taken: _____
_____

Home treatments/exercises administered: _____
_____
_____

Progress of Recovery/Notes on Symptoms: _____
_____
_____
_____
_____
_____

Week 5

Date(s): _____

Average pain intensity rating (1-10):
1 2 3 4 5 6 7 8 9 10

Medical Appointments (circle day(s) of the week):
M T W Th F Sat Sun

Type of Doctor (circle those that apply):
MD DC DO PT Acupuncturist

Describe treatment provided: _____
_____

Medications taken: _____
_____

Home treatments/exercises administered: _____
_____
_____

Progress of Recovery/Notes on Symptoms: _____
_____
_____
_____
_____
_____

Week 6

Date(s): _____

Average pain intensity rating (1-10):
1 2 3 4 5 6 7 8 9 10

Medical Appointments (circle day(s) of the week):
M T W Th F Sat Sun

Type of Doctor (circle those that apply):
MD DC DO PT Acupuncturist

Describe treatment provided: _____
_____

Medications taken: _____
_____

Home treatments/exercises administered: _____
_____
_____

Progress of Recovery/Notes on Symptoms: _____
_____
_____
_____
_____
_____

Week 7

Date(s): _____

Average pain intensity rating (1-10):
1 2 3 4 5 6 7 8 9 10

Medical Appointments (circle day(s) of the week):
M T W Th F Sat Sun

Type of Doctor (circle those that apply):
MD DC DO PT Acupuncturist

Describe treatment provided: _____
_____

Medications taken: _____
_____

Home treatments/exercises administered: _____
_____
_____

Progress of Recovery/Notes on Symptoms: _____
_____
_____
_____
_____
_____

Week 8

Date(s): _____

Average pain intensity rating (1-10):
1 2 3 4 5 6 7 8 9 10

Medical Appointments (circle day(s) of the week):
M T W Th F Sat Sun

Type of Doctor (circle those that apply):
MD DC DO PT Acupuncturist

Describe treatment provided: _____
_____

Medications taken: _____
_____

Home treatments/exercises administered: _____
_____
_____

Progress of Recovery/Notes on Symptoms: _____
_____
_____
_____
_____
_____

Week 9

Date(s): _____

Average pain intensity rating (1-10):
1 2 3 4 5 6 7 8 9 10

Medical Appointments (circle day(s) of the week):
M T W Th F Sat Sun

Type of Doctor (circle those that apply):
MD DC DO PT Acupuncturist

Describe treatment provided: _____
_____

Medications taken: _____
_____

Home treatments/exercises administered: _____
_____
_____

Progress of Recovery/Notes on Symptoms: _____
_____
_____
_____
_____
_____

Week 10

Date(s): _____

Average pain intensity rating (1-10):
1 2 3 4 5 6 7 8 9 10

Medical Appointments (circle day(s) of the week):
M T W Th F Sat Sun

Type of Doctor (circle those that apply):
MD DC DO PT Acupuncturist

Describe treatment provided: _____
_____

Medications taken: _____
_____

Home treatments/exercises administered: _____
_____
_____

Progress of Recovery/Notes on Symptoms: _____
_____
_____
_____
_____
_____

Week 11

Date(s): _____

Average pain intensity rating (1-10):
1 2 3 4 5 6 7 8 9 10

Medical Appointments (circle day(s) of the week):
M T W Th F Sat Sun

Type of Doctor (circle those that apply):
MD DC DO PT Acupuncturist

Describe treatment provided: _____
_____

Medications taken: _____
_____

Home treatments/exercises administered: _____
_____
_____

Progress of Recovery/Notes on Symptoms: _____
_____
_____
_____
_____
_____

Week 12

Date(s): _____

Average pain intensity rating (1-10):
1 2 3 4 5 6 7 8 9 10

Medical Appointments (circle day(s) of the week):
M T W Th F Sat Sun

Type of Doctor (circle those that apply):
MD DC DO PT Acupuncturist

Describe treatment provided: _____
_____

Medications taken: _____
_____

Home treatments/exercises administered: _____
_____
_____

Progress of Recovery/Notes on Symptoms: _____
_____
_____
_____
_____
_____

Loss of Earnings

Week 1

Date(s) missed work: _____

Employer: _____

Your job title: _____

Your work duties: _____

_____

_____

You lost _____ hours of work at $ _____ hour

You lost _____ hours of overtime at $ _____ hour

Did you forfeit any benefits due to the accident? Yes ___ No ___
If yes, explain in detail: _____

_____

_____

Any other loss related to your work: _____

_____

_____

_____

_____

_____

Week 2

Date(s) missed work: _____

Employer: _____

Your job title: _____

Your work duties: _____

_____

_____

You lost _____ hours of work at $ _____ hour

You lost _____ hours of overtime at $ _____ hour

Did you forfeit any benefits due to the accident? Yes ___ No ___
If yes, explain in detail: _____

_____

_____

Any other loss related to your work: _____

_____

_____

_____

_____

_____

Week 3

Date(s) missed work: _____

Employer: _____

Your job title: _____

Your work duties: _____

_____

_____

You lost _____ hours of work at $ _____ hour

You lost _____ hours of overtime at $ _____ hour

Did you forfeit any benefits due to the accident? Yes ___ No ___
If yes, explain in detail: _____

_____

_____

Any other loss related to your work: _____

_____

_____

_____

_____

_____

Week 4

Date(s) missed work: _____

Employer: _____

Your job title: _____

Your work duties: _____

_____

_____

You lost _____ hours of work at $ _____ hour

You lost _____ hours of overtime at $ _____ hour

Did you forfeit any benefits due to the accident? Yes ___ No ___
If yes, explain in detail: _____

_____

_____

Any other loss related to your work: _____

_____

_____

_____

_____

_____

Week 5

Date(s) missed work: _____

Employer: _____

Your job title: _____

Your work duties: _____

_____

_____

You lost _____ hours of work at $ _____ hour

You lost _____ hours of overtime at $ _____ hour

Did you forfeit any benefits due to the accident? Yes ___ No ___
If yes, explain in detail: _____

_____

_____

Any other loss related to your work: _____

_____

_____

_____

_____

_____

Week 6

Date(s) missed work: _____

Employer: _____

Your job title: _____

Your work duties: _____

_____

_____

You lost _____ hours of work at $ _____ hour

You lost _____ hours of overtime at $ _____ hour

Did you forfeit any benefits due to the accident? Yes ___ No ___
If yes, explain in detail: _____

_____

_____

Any other loss related to your work: _____

_____

_____

_____

_____

_____

Week 7

Date(s) missed work: _____

Employer: _____

Your job title: _____

Your work duties: _____

_____

_____

You lost _____ hours of work at $ _____ hour

You lost _____ hours of overtime at $ _____ hour

Did you forfeit any benefits due to the accident? Yes ___ No ___
If yes, explain in detail: _____

_____

_____

Any other loss related to your work: _____

_____

_____

_____

_____

_____

Week 8

Date(s) missed work: _____

Employer: _____

Your job title: _____

Your work duties: _____

_____

_____

You lost _____ hours of work at $ _____ hour

You lost _____ hours of overtime at $ _____ hour

Did you forfeit any benefits due to the accident? Yes ___ No ___
If yes, explain in detail: _____

_____

_____

Any other loss related to your work: _____

_____

_____

_____

_____

_____

Week 9

Date(s) missed work: _____

Employer: _____

Your job title: _____

Your work duties: _____

_____

_____

You lost _____ hours of work at $ _____ hour

You lost _____ hours of overtime at $ _____ hour

Did you forfeit any benefits due to the accident? Yes ___ No ___
If yes, explain in detail: _____

_____

_____

Any other loss related to your work: _____

_____

_____

_____

_____

_____

Week 10

Date(s) missed work: _____

Employer: _____

Your job title: _____

Your work duties: _____

_____

_____

You lost _____ hours of work at $ _____ hour

You lost _____ hours of overtime at $ _____ hour

Did you forfeit any benefits due to the accident? Yes ___ No ___
If yes, explain in detail: _____

_____

_____

Any other loss related to your work: _____

_____

_____

_____

_____

_____

Week 11

Date(s) missed work: _____

Employer: _____

Your job title: _____

Your work duties: _____

_____

_____

You lost _____ hours of work at $ _____ hour

You lost _____ hours of overtime at $ _____ hour

Did you forfeit any benefits due to the accident? Yes ___ No ___
If yes, explain in detail: _____

_____

_____

Any other loss related to your work: _____

_____

_____

_____

_____

_____

Week 12

Date(s) missed work: _____

Employer: _____

Your job title: _____

Your work duties: _____

_____

_____

You lost _____ hours of work at $ _____ hour

You lost _____ hours of overtime at $ _____ hour

Did you forfeit any benefits due to the accident? Yes ___ No ___
If yes, explain in detail: _____

_____

_____

Any other loss related to your work: _____

_____

_____

_____

_____

_____

Also By Joseph M. Ghabour

Your Car is Wrecked! Don't Wreck Your Injury Case
-Guide to Auto Injury Claims

When the Open Road is Not So Friendly
-Guide to Motorcycle Accident Claims

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- Cycling your Way to Recovery and Compensation

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-Know What You are Walking Into

A Simple Guide to Auto Insurance
-How Much is Enough Coverage?

DIARY FOR THE INJURED

A WORKBOOK FOR RECORDING YOUR INJURIES & LOSSES

When it comes to receiving fair compensation from insurance companies, documentation is everything. That's why I created *Diary for the Injured*. I wanted to provide an easy-to-use tool to help you, your doctor and your attorney ensure that the facts of your accident and the full extent of your injuries are understood and well documented.

Your memory of the accident is a valuable source of information, but it becomes less and less reliable as time passes, and important details can be forgotten. So, as soon as you can after the accident, sit down and fill out the "Accident Record" section below.

Both you and your doctor are responsible for documenting your injuries, but each of you has a different job to do. Your job is to record the ways in which your injuries impact you from a personal perspective: the pain you feel, the activities in which you can no longer engage and any other ways in which the injuries have impacted your life.

To that end, I've also included the "Documenting Your Injuries" section. It contains both specific questions regarding your symptoms and a convenient format for tracking them over the course of several months.

By taking these steps—writing an account of your accident and tracking your symptoms during your recovery— you are doing yourself a tremendous favor: you are helping to ensure that you will be able to obtain the financial resources you need to fully recover.

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