Print This Template

DAILY PAIN & SUFFERING JOURNAL

Date: _____ **Day of Week:** _____

Time of Entry: _____ **Weather:** _____

PAIN LEVEL ASSESSMENT

Rate your overall pain level today (Circle one):

0	1	2	3	4	5	6	7	8	9	10
No Pain			Mild		Moderate		Severe			Worst

PHYSICAL SYMPTOMS (Check all that apply)

- ☐ Sharp/Stabbing Pain
- ☐ Throbbing Pain
- ☐ Numbness/Tingling
- ☐ Swelling/Inflammation
- ☐ Fatigue/Exhaustion
- ☐ Muscle Spasms
- ☐ Dull/Aching Pain
- ☐ Burning Sensation
- ☐ Stiffness/Limited Mobility
- ☐ Headache/Migraine
- ☐ Nausea/Dizziness
- ☐ Joint Pain

Location & Description of Pain:

Describe where you feel pain, if it radiates, what makes it better/worse, and duration.

MEDICATIONS & TREATMENTS

- ☐ Prescribed Medication
- ☐ Over-the-Counter Medication
- ☐ Physical Therapy
- ☐ Ice/Heat Application
- ☐ Rest/Limited Activity
- ☐ Massage Therapy

Medication Details & Side Effects:

List all medications taken today, dosage, time taken, and any side effects experienced.

DAILY ACTIVITIES AFFECTED (Check all that apply)

- ☐ Sleep Disturbance
- ☐ Household Chores
- ☐ Personal Care (bathing, dressing)
- ☐ Exercise/Physical Activity
- ☐ Hobbies/Recreation
- ☐ Shopping/Errands
- ☐ Sitting for Extended Periods
- ☐ Work (Unable/Limited)
- ☐ Cooking/Meal Prep
- ☐ Driving
- ☐ Social Activities
- ☐ Childcare/Family Care
- ☐ Walking/Standing
- ☐ Lifting/Carrying Objects

Specific Activity Impact:

Describe what activities you attempted, how long, what you couldn't do, and what you had to ask others to do for you.

MEDICAL APPOINTMENTS TODAY

- ☐ Primary Care Doctor
- ☐ Physical/Occupational Therapy
- ☐ Emergency Room
- ☐ Specialist Visit
- ☐ Imaging/Tests (X-ray, MRI, CT)
- ☐ Mental Health Provider

Appointment Details:

Provider name, reason for visit, diagnosis/findings, treatments recommended, next appointment scheduled.

EMOTIONAL & MENTAL HEALTH

- ☐ Anxiety/Stress
- ☐ Frustration/Irritability
- ☐ Social Isolation/Loneliness
- ☐ Loss of Enjoyment in Activities
- ☐ Depression/Sadness
- ☐ Fear/Worry About Future
- ☐ Relationship Strain
- ☐ Difficulty Concentrating

Emotional Impact Description:

Describe how you felt emotionally today and how your injuries affected your mood, relationships, and quality of life.

SLEEP QUALITY

Hours of sleep last night: _____ | Times awakened by pain: _____ | Quality (1-10): _____

ADDITIONAL NOTES

Include: weather effects, events missed, financial impacts, help needed from family/friends, photos taken, witnesses present, etc.

IMPORTANT REMINDERS:

• Complete this journal daily, even on good days • Be specific and honest • Keep original in safe place
• Share copies with your attorney • Take photos when relevant • Note witnesses to your limitations

Print This Template