

***YOUR* INJURY JOURNAL**

A workbook designed to organize and survey your incident
& injury throughout the road to recovery

SLIP/FALL



CAR ACCIDENT



WORKERS COMP



TY WILSON LAW

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Contents

Your Injury	1
Information Regarding Your Injury Car Wreck	3
Details of Incident - Car Wreck	7
Details of Incident - Slip/Fall	9
Documenting Your Injuries	11
Specific Areas of the Body	13
Activity/Behavior Checklist	21
Recovery Diary	23
Weekly Progression of Medical Treatment	24
Wage Loss	37

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Your Injury Journal

If you have been injured by someone else and have a claim, you likely will be dealing with an insurance company. You may even be obligated to prove your injuries in a court of law to either a judge or a jury.

Regardless of who you have to prove your damages to, the most important component of proving your damages is accurate documentation.

This Injury Diary is designed as a tool for you to use to document your injury and the progression of your medical care. While your doctors will document your injuries from a medical prospective or view, your documentation is used to prove the harms that have occurred to you and how they have changed your life.

Often times if you are forced to go to court for an injury, it can be a long time after you have experienced the injury - sometimes many years. As much as we try, no one's memory is accurate after several years. The fact is, our memory is most accurate shortly after an event has occurred.

We often play tricks on ourselves and can convince ourselves of something that did not occur if it goes unchallenged in our own minds. As time goes by, we have new memories that enter our minds and push out older memories. This is critically important with eye witnesses. Therefore, the best time to use this tool is shortly after you have been injured.

By addressing the events that occurred to create the injury and addressing your medical care and healing progress, you will help yourself in proving your injuries. Also you can use this information to review should your claim or case take several years.

The ultimate goal is to maximize the recovery for the harms and losses you have.

Information Regarding Your Injury – Car Wreck



Other Driver Information: (Request drivers' license)

Name: _____

Address: _____

Phone Number: _____

Drivers' License Number: _____ Date of Birth: _____

Other Vehicle: Year, Make & Model: _____

License Plate Number: _____ VIN #: _____

Where is the vehicle damaged: (photograph if possible) _____

Owner's Name: _____

Owner's Address: _____

Owner's Phone Number: _____

Insurance Company: _____ Policy Number: _____

Responding Police Officer Name : _____ Badge No. _____

Responding Police Department: _____

Police Report No. _____ Citation Issued? Yes or No

Witness One Name: _____

Address: _____

What they saw: _____

Witness Two Name: _____

Address: _____

What they saw: _____

Witness Three Name: _____

Address: _____

What they saw: _____

Witness Four Name: _____

Address: _____

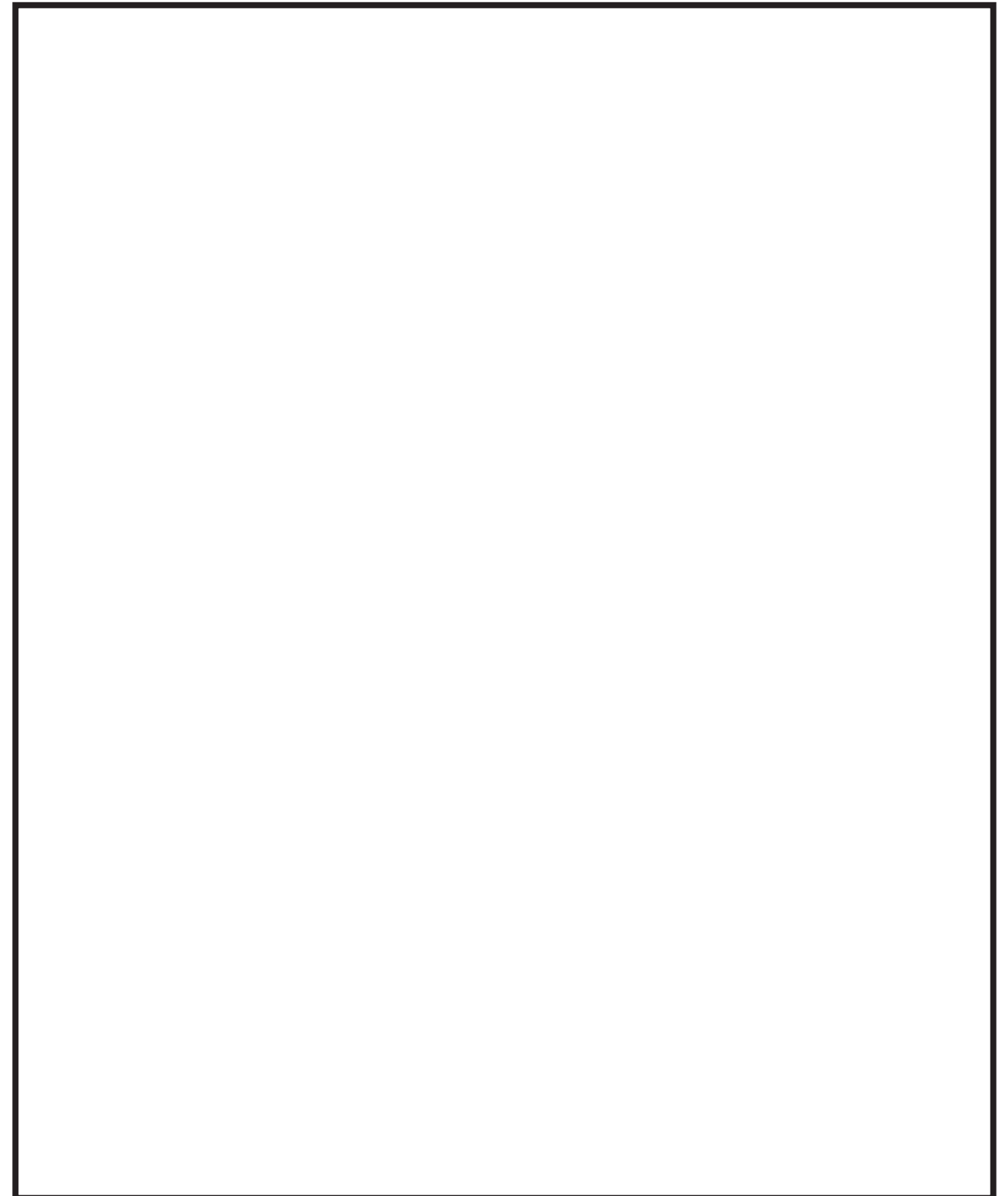
What they saw: _____

Witness Five Name: _____

Address: _____

What they saw: _____

Draw the roadway below including how many lanes and the position of each vehicle related to the collision.



Details of Incident

– *Car Wreck*



Date of Incident: _____

Time of Incident: _____

Location of Incident: _____

Weather Conditions: _____

Road Conditions: _____

What City or County: _____

How did the Incident Happen: _____

My Injuries: (Head to toe - everything that hurts) _____

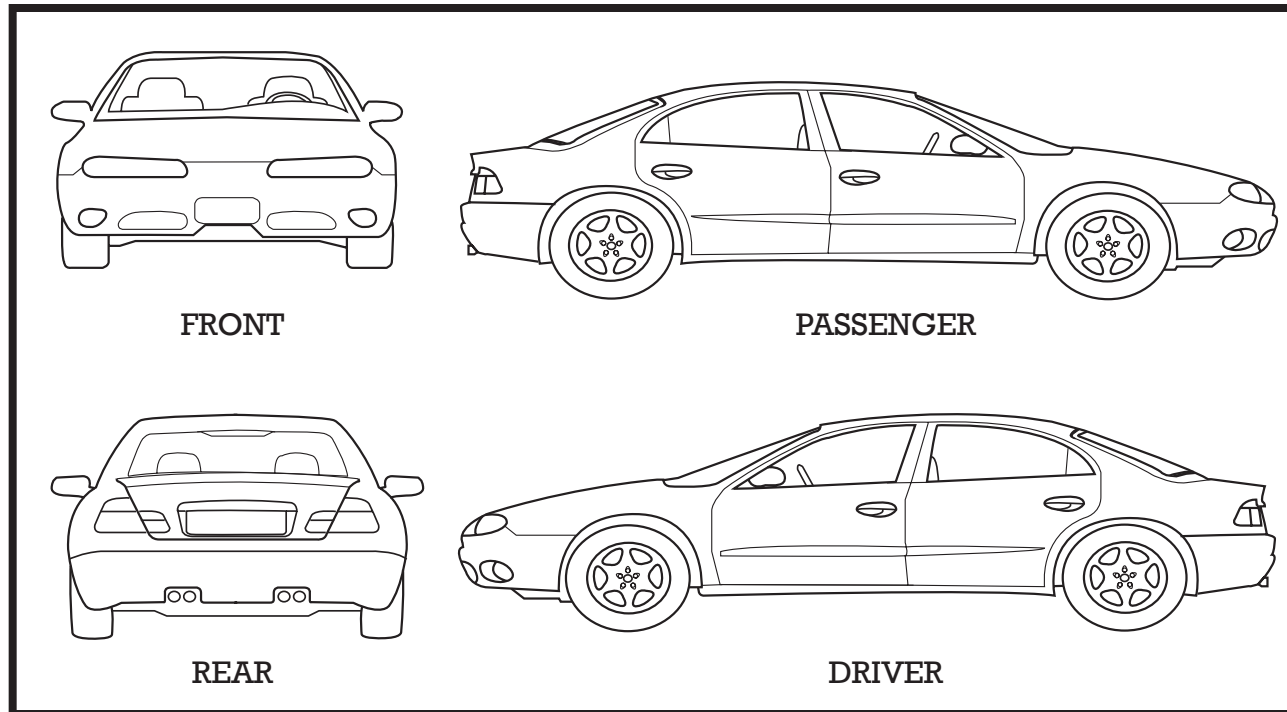
Taken from the incident scene by ambulance? Yes or No

Name of Hospital: _____

Any Other Injuries to Other People? Yes or No

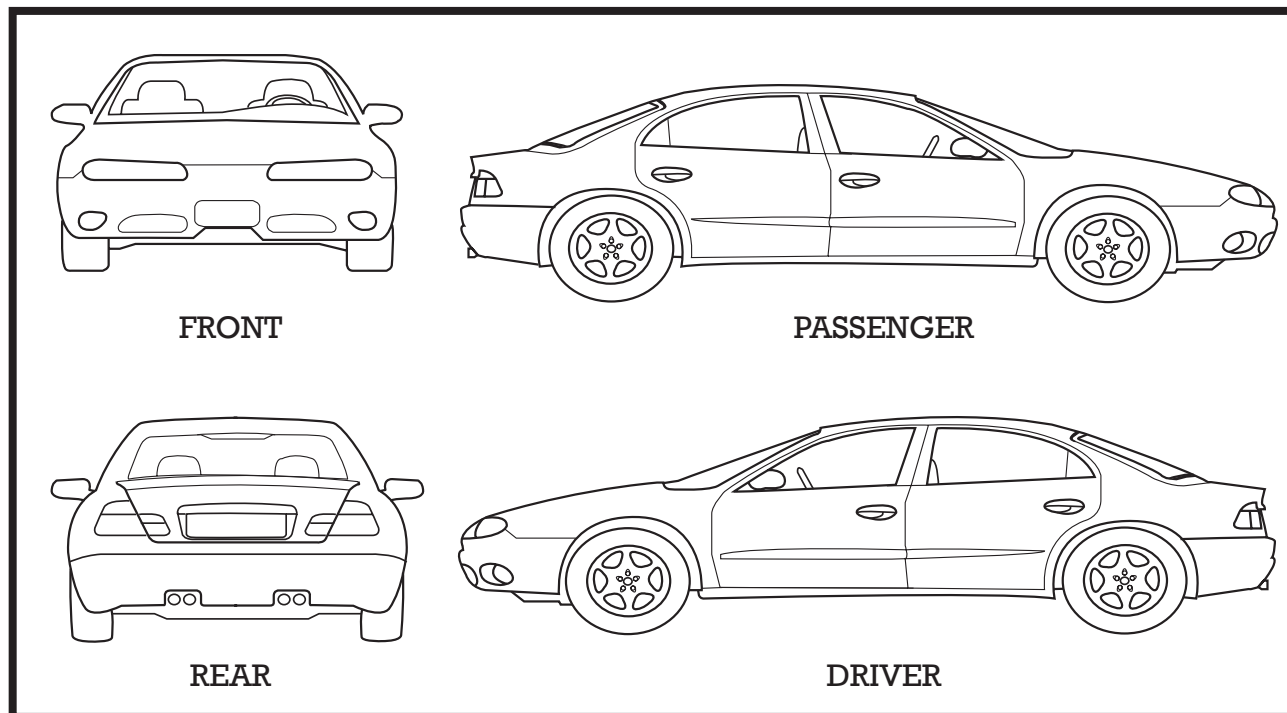
Damage to My Vehicle:

Circle the part of the vehicle which was damaged by the collision.



Damage to the Other Vehicle(s):

Circle the part of the vehicle which was damaged by the collision.



Information Regarding Your Injury

– Slip/Fall



Not all injuries are related to car wreck claims. If you have been injured in a slip/fall type injury, you should complete the information below:

Date of Incident: _____

Time of Incident: _____

Weather conditions: _____

Address of Incident: _____

Name of Place: _____

Where were you injured? (Location): _____

What caused you to slip/fall? _____

Have you ever previously visited the same place? Yes or No

Had you come upon the same danger that caused the slip/fall before? Yes or No

How was the lighting? _____

What type of shoes were you wearing? _____

What type of clothing were you wearing? _____

Have you washed the clothing since the incident? Yes or No
(May be needed for expert analysis depending upon the nature of the fall)

Have you worn the shoes you were wearing since the incident? Yes or No

Were there any signs warning you of the dangerous condition? Yes or No

How did the Incident happen: _____

My Injuries: (Head to toe - everything that hurts) _____

Taken from the incident scene by ambulance? Yes or No

Name of Hospital: _____

Witness One Name: _____

Address: _____

What they saw: _____

Witness Two Name: _____

Address: _____

What they saw: _____

Witness Three Name: _____

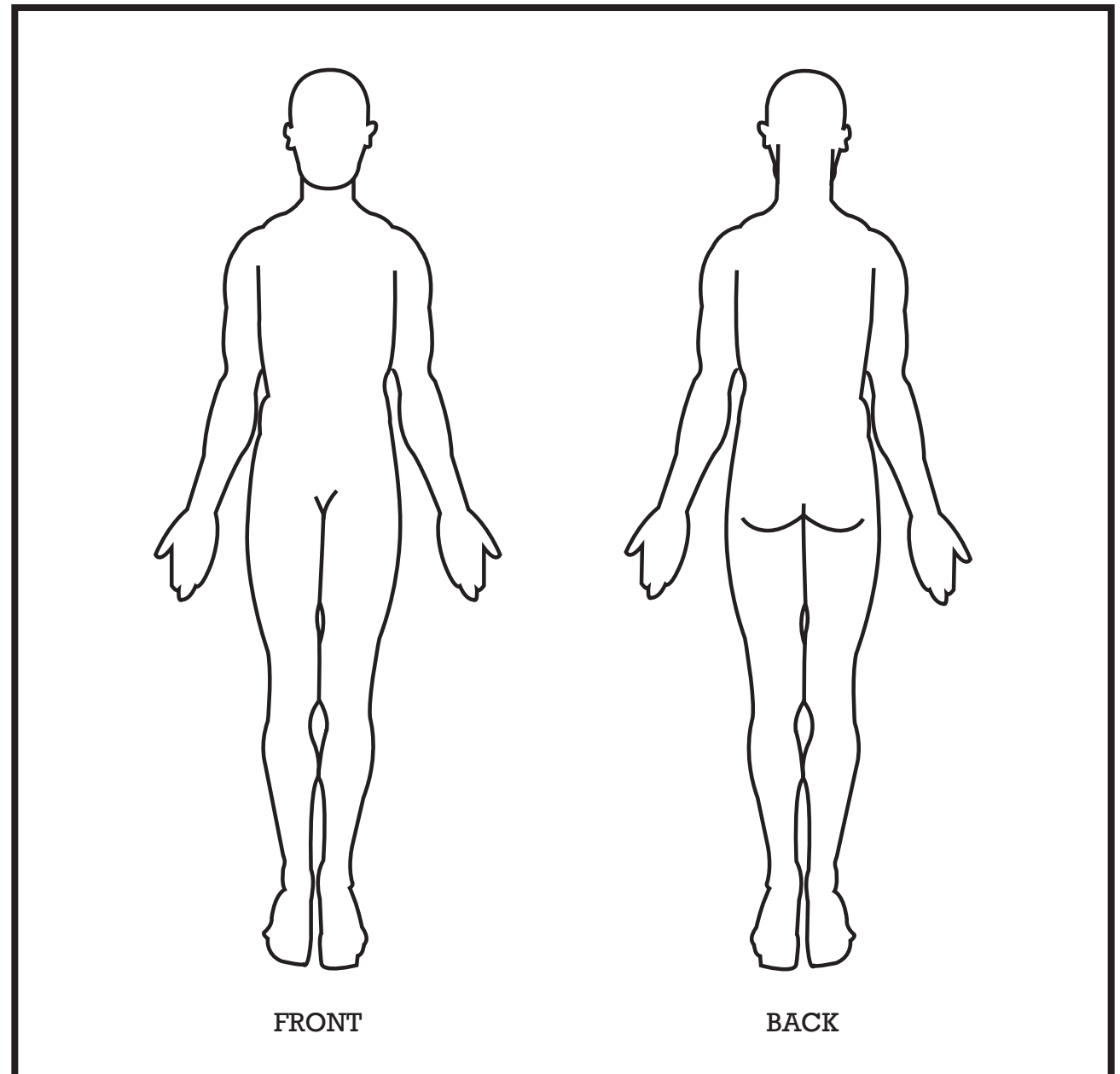
Address: _____

What they saw: _____

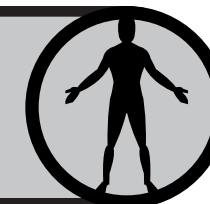
Information Regarding Your Injury – Documenting Your Injuries

Where Does it Hurt?

Please put an X where you were injured as a result of the collision or fall.



Specific Areas of the Body



Headache Pain: circle one Yes or No

Pain Level : 1 being least painful and 10 being extremely painful.

1 2 3 4 5 6 7 8 9 10

Regularity of Pain: Is the pain constant or does the pain come and go?

Aggravate: When does the pain hurt most?
Is there anything that causes or aggravates the pain?

Improvement: Are you feeling better or worse?
Is there anything you do that minimizes the pain?

Neck Pain: circle one Yes or No

Pain Level : 1 being least painful and 10 being extremely painful.

1 2 3 4 5 6 7 8 9 10

Regularity of Pain: Is the pain constant or does the pain come and go?

Aggravate: When does the pain hurt most?
Is there anything that causes or aggravates the pain?

Improvement: Are you feeling better or worse?
Is there anything you do that minimizes the pain?

Right Shoulder Pain: circle one Yes or No

Pain Level : 1 being least painful and 10 being extremely painful.

1 2 3 4 5 6 7 8 9 10

Regularity of Pain: Is the pain constant or does the pain come and go?

Aggravate: When does the pain hurt most?
Is there anything that causes or aggravates the pain?

Improvement: Are you feeling better or worse?
Is there anything you do that minimizes the pain?

Left Shoulder Pain: circle one Yes or No

Pain Level : 1 being least painful and 10 being extremely painful.

1 2 3 4 5 6 7 8 9 10

Regularity of Pain: Is the pain constant or does the pain come and go?

Aggravate: When does the pain hurt most?
Is there anything that causes or aggravates the pain?

Improvement: Are you feeling better or worse?
Is there anything you do that minimizes the pain?

Right Arm Pain: circle one Yes or No

Pain Level : 1 being least painful and 10 being extremely painful.

1 2 3 4 5 6 7 8 9 10

Regularity of Pain: Is the pain constant or does the pain come and go?

Aggravate: When does the pain hurt most?
Is there anything that causes or aggravates the pain?

Improvement: Are you feeling better or worse?
Is there anything you do that minimizes the pain?

Left Arm Pain: circle one Yes or No

Pain Level : 1 being least painful and 10 being extremely painful.

1 2 3 4 5 6 7 8 9 10

Regularity of Pain: Is the pain constant or does the pain come and go?

Aggravate: When does the pain hurt most?
Is there anything that causes or aggravates the pain?

Improvement: Are you feeling better or worse?
Is there anything you do that minimizes the pain?

Mid Back Pain: circle one Yes or No

Pain Level : 1 being least painful and 10 being extremely painful.

1 2 3 4 5 6 7 8 9 10

Regularity of Pain: Is the pain constant or does the pain come and go?

Aggravate: When does the pain hurt most?
Is there anything that causes or aggravates the pain?

Improvement: Are you feeling better or worse?
Is there anything you do that minimizes the pain?

Low Back Pain: circle one Yes or No

Pain Level : 1 being least painful and 10 being extremely painful.

1 2 3 4 5 6 7 8 9 10

Regularity of Pain: Is the pain constant or does the pain come and go?

Aggravate: When does the pain hurt most?
Is there anything that causes or aggravates the pain?

Improvement: Are you feeling better or worse?
Is there anything you do that minimizes the pain?

Right Knee Pain: circle one Yes or No

Pain Level : 1 being least painful and 10 being extremely painful.

1 2 3 4 5 6 7 8 9 10

Regularity of Pain: Is the pain constant or does the pain come and go?

Aggravate: When does the pain hurt most?
Is there anything that causes or aggravates the pain?

Improvement: Are you feeling better or worse?
Is there anything you do that minimizes the pain?

Left Knee Pain: circle one Yes or No

Pain Level : 1 being least painful and 10 being extremely painful.

1 2 3 4 5 6 7 8 9 10

Regularity of Pain: Is the pain constant or does the pain come and go?

Aggravate: When does the pain hurt most?
Is there anything that causes or aggravates the pain?

Improvement: Are you feeling better or worse?
Is there anything you do that minimizes the pain?

Right Ankle or Foot Pain: circle one Yes or No

Pain Level : 1 being least painful and 10 being extremely painful.

1 2 3 4 5 6 7 8 9 10

Regularity of Pain: Is the pain constant or does the pain come and go?

Aggravate: When does the pain hurt most?
Is there anything that causes or aggravates the pain?

Improvement: Are you feeling better or worse?
Is there anything you do that minimizes the pain?

Left Ankle or Foot Pain: circle one Yes or No

Pain Level : 1 being least painful and 10 being extremely painful.

1 2 3 4 5 6 7 8 9 10

Regularity of Pain: Is the pain constant or does the pain come and go?

Aggravate: When does the pain hurt most?
Is there anything that causes or aggravates the pain?

Improvement: Are you feeling better or worse?
Is there anything you do that minimizes the pain?

Below is a list of symptoms. Please check the box if you have these symptoms and how often you experience these symptoms.

Symptom	Often	Constantly	Occasionally	Never
Difficulty Concentrating				
Gaps in Memory				
Disoriented				
Dizzy				
Unable To Sleep				
Sleeping Too Much				
Constantly Exhausted				
Depression				
Anxieties				
Nausea and/or Vomiting				
Sensitive To Light				
Irritable				

How Would You Rate Your Pain Today?

Date: _____

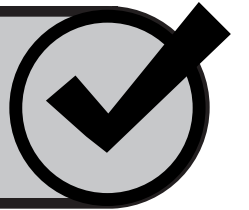
Overall Pain Level: 1 2 3 4 5 6 7 8 9 10

Body part that hurts the most: _____

Other body parts that hurt to a lesser degree? _____

Is the pain getting better or worse? _____

Activity/Behavior Checklist



Instructions to client: Use the following checklist to indicate the activities which have been substantially limited, impaired, or affected by your injury. After each activity category, complete the specific activity that has been affected and then list the name or names of the best witnesses who can testify about how the injury has affected the activity. Remember, the best witness would be someone who is objective, impartial, and who has had the opportunity to observe you in the activity both before and after your injury.

	Specific Activity Affected	Name & Address of Witness
Sports and Exercise		
Hobbies		
Social Activities (Dancing, Holiday Activities)		
Household Chores		
Gardening Chores		
Activities With Children		
Personal Activities		

Weekly Progression of Medical Treatment – Week One:

Date: _____

Where did you go for medical treatment? _____

What medical provider did you treat with? _____

Address: _____

How many miles did you drive from your home to the medical provider? _____

Your Chief Complaint (What bothers you the most)? _____

What type of medical treatment did you receive? _____

Where you prescribed any medicines or medical devices? If so, what? _____

What did the medical provider tell you about your progress and how much more
treatment you will need? _____

Were you referred to a specialist or for further testing? (MRI, EMG Nerve Conduction)

What is your work status? (No Work, Light or Restricted Duty or Full Duty) _____

What is your average level of pain this week?

1 2 3 4 5 6 7 8 9 10

Weekly Progression of Medical Treatment – Week Two:

Date: _____

Where did you go for medical treatment? _____

What medical provider did you treat with? _____

Address: _____

How many miles did you drive from your home to the medical provider? _____

Your Chief Complaint (What bothers you the most)? _____

What type of medical treatment did you receive? _____

Where you prescribed any medicines or medical devices? If so, what? _____

What did the medical provider tell you about your progress and how much more
treatment you will need? _____

Were you referred to a specialist or for further testing? (MRI, EMG Nerve Conduction)

What is your work status? (No Work, Light or Restricted Duty or Full Duty) _____

What is your average level of pain this week?

1 2 3 4 5 6 7 8 9 10

Weekly Progression of Medical Treatment – Week Three:

Date: _____

Where did you go for medical treatment? _____

What medical provider did you treat with? _____

Address: _____

How many miles did you drive from your home to the medical provider? _____

Your Chief Complaint (What bothers you the most)? _____

What type of medical treatment did you receive? _____

Where you prescribed any medicines or medical devices? If so, what? _____

What did the medical provider tell you about your progress and how much more
treatment you will need? _____

Were you referred to a specialist or for further testing? (MRI, EMG Nerve Conduction)

What is your work status? (No Work, Light or Restricted Duty or Full Duty) _____

What is your average level of pain this week?

1 2 3 4 5 6 7 8 9 10

Weekly Progression of Medical Treatment – Week Four:

Date: _____

Where did you go for medical treatment? _____

What medical provider did you treat with? _____

Address: _____

How many miles did you drive from your home to the medical provider? _____

Your Chief Complaint (What bothers you the most)? _____

What type of medical treatment did you receive? _____

Where you prescribed any medicines or medical devices? If so, what? _____

What did the medical provider tell you about your progress and how much more
treatment you will need? _____

Were you referred to a specialist or for further testing? (MRI, EMG Nerve Conduction)

What is your work status? (No Work, Light or Restricted Duty or Full Duty) _____

What is your average level of pain this week?

1 2 3 4 5 6 7 8 9 10

Weekly Progression of Medical Treatment – Week Five:

Date: _____

Where did you go for medical treatment? _____

What medical provider did you treat with? _____

Address: _____

How many miles did you drive from your home to the medical provider? _____

Your Chief Complaint (What bothers you the most)? _____

What type of medical treatment did you receive? _____

Where you prescribed any medicines or medical devices? If so, what? _____

What did the medical provider tell you about your progress and how much more

treatment you will need? _____

Were you referred to a specialist or for further testing? (MRI, EMG Nerve Conduction)

What is your work status? (No Work, Light or Restricted Duty or Full Duty) _____

What is your average level of pain this week?

1 2 3 4 5 6 7 8 9 10

Weekly Progression of Medical Treatment – Week Six:

Date: _____

Where did you go for medical treatment? _____

What medical provider did you treat with? _____

Address: _____

How many miles did you drive from your home to the medical provider? _____

Your Chief Complaint (What bothers you the most)? _____

What type of medical treatment did you receive? _____

Where you prescribed any medicines or medical devices? If so, what? _____

What did the medical provider tell you about your progress and how much more

treatment you will need? _____

Were you referred to a specialist or for further testing? (MRI, EMG Nerve Conduction)

What is your work status? (No Work, Light or Restricted Duty or Full Duty) _____

What is your average level of pain this week?

1 2 3 4 5 6 7 8 9 10

Weekly Progression of Medical Treatment – Week Seven:

Date: _____

Where did you go for medical treatment? _____

What medical provider did you treat with? _____

Address: _____

How many miles did you drive from your home to the medical provider? _____

Your Chief Complaint (What bothers you the most)? _____

What type of medical treatment did you receive? _____

Where you prescribed any medicines or medical devices? If so, what? _____

What did the medical provider tell you about your progress and how much more treatment you will need? _____

Were you referred to a specialist or for further testing? (MRI, EMG Nerve Conduction)

What is your work status? (No Work, Light or Restricted Duty or Full Duty) _____

What is your average level of pain this week?

1 2 3 4 5 6 7 8 9 10

Weekly Progression of Medical Treatment – Week Eight:

Date: _____

Where did you go for medical treatment? _____

What medical provider did you treat with? _____

Address: _____

How many miles did you drive from your home to the medical provider? _____

Your Chief Complaint (What bothers you the most)? _____

What type of medical treatment did you receive? _____

Where you prescribed any medicines or medical devices? If so, what? _____

What did the medical provider tell you about your progress and how much more treatment you will need? _____

Were you referred to a specialist or for further testing? (MRI, EMG Nerve Conduction)

What is your work status? (No Work, Light or Restricted Duty or Full Duty) _____

What is your average level of pain this week?

1 2 3 4 5 6 7 8 9 10

Weekly Progression of Medical Treatment – Week Nine:

Date: _____

Where did you go for medical treatment? _____

What medical provider did you treat with? _____

Address: _____

How many miles did you drive from your home to the medical provider? _____

Your Chief Complaint (What bothers you the most)? _____

What type of medical treatment did you receive? _____

Where you prescribed any medicines or medical devices? If so, what? _____

What did the medical provider tell you about your progress and how much more

treatment you will need? _____

Were you referred to a specialist or for further testing? (MRI, EMG Nerve Conduction)

What is your work status? (No Work, Light or Restricted Duty or Full Duty) _____

What is your average level of pain this week?

1 2 3 4 5 6 7 8 9 10

Weekly Progression of Medical Treatment – Week Ten:

Date: _____

Where did you go for medical treatment? _____

What medical provider did you treat with? _____

Address: _____

How many miles did you drive from your home to the medical provider? _____

Your Chief Complaint (What bothers you the most)? _____

What type of medical treatment did you receive? _____

Where you prescribed any medicines or medical devices? If so, what? _____

What did the medical provider tell you about your progress and how much more

treatment you will need? _____

Were you referred to a specialist or for further testing? (MRI, EMG Nerve Conduction)

What is your work status? (No Work, Light or Restricted Duty or Full Duty) _____

What is your average level of pain this week?

1 2 3 4 5 6 7 8 9 10

Weekly Progression of Medical Treatment – Week Eleven:

Date: _____

Where did you go for medical treatment? _____

What medical provider did you treat with? _____

Address: _____

How many miles did you drive from your home to the medical provider? _____

Your Chief Complaint (What bothers you the most)? _____

What type of medical treatment did you receive? _____

Where you prescribed any medicines or medical devices? If so, what? _____

What did the medical provider tell you about your progress and how much more

treatment you will need? _____

Were you referred to a specialist or for further testing? (MRI, EMG Nerve Conduction)

What is your work status? (No Work, Light or Restricted Duty or Full Duty) _____

What is your average level of pain this week?

1 2 3 4 5 6 7 8 9 10

Weekly Progression of Medical Treatment – Week Twelve:

Date: _____

Where did you go for medical treatment? _____

What medical provider did you treat with? _____

Address: _____

How many miles did you drive from your home to the medical provider? _____

Your Chief Complaint (What bothers you the most)? _____

What type of medical treatment did you receive? _____

Where you prescribed any medicines or medical devices? If so, what? _____

What did the medical provider tell you about your progress and how much more

treatment you will need? _____

Were you referred to a specialist or for further testing? (MRI, EMG Nerve Conduction)

What is your work status? (No Work, Light or Restricted Duty or Full Duty) _____

What is your average level of pain this week?

1 2 3 4 5 6 7 8 9 10

Wage Loss



In this section, the goal is to list the days and partial days you missed from work so you will not need to recreate this several months or years after you have fully recovered.

What do you do for a living? _____

What type of duties are you required to do? _____

Name of employer: _____

What is your employer's address? _____

What is your supervisor or payroll person's name and title? _____

How much and how are you paid? (Salary, Hourly, Per Day) _____

Did you miss any bonuses as a result of not being able to work because of your injuries? (Please explain). _____

Days missed: _____

Partial days missed: _____

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***YOUR* INJURY JOURNAL**

Georgia attorney Ty Wilson has dedicated his legal career to representing people against insurance companies. Shortly after law school, Mr. Wilson worked for a big defense law firm before realizing that his true calling was in helping people—not businesses.



Ty completed his legal education in Atlanta, Georgia and shortly after passing the Georgia Bar, he took on a job working with a large downtown Atlanta firm primarily working in extensive discovery production for complex pharmaceutical tort litigation.



When the opportunity arose to help people who have been hurt by others, the decision was easy. Believing that helping people was far more rewarding than helping billion dollar companies, Ty left the big Atlanta law firm for a small practice. Ty helped the small practice become a medium size practice, before starting his own law firm focused on helping people who have been injured.



That outlook is what led to the creation of this book. Inside readers will find a complete injury diary. After a collision, fall, or accident it can be very difficult to keep a clear and focused mind. With that in consideration Ty put together this journal to aid in the organization of injuries, information, and experiences during these most crucial moments.



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