

WAGE AND INCOME LOSS

NAME OF CLIENT _____

Please keep an accurate record of time you lost from work as a result of your accident; amount you were paid by your employer or others; the reason for your absence. Do not subtract taxes, etc. from amount of income lost.

DATE	REASON	AMOUNT
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____

PAIN AND DISCOMFORT

NAME OF CLIENT _____

On first signs of pain or discomfort, call your doctor and follow his instructions. Do not exaggerate or minimize complaints. Explain your complaints fully and record the appropriate information below.

DATE	COMPLAINT	Rx TAKEN
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

HOSPITAL EXPENSES

NAME OF CLIENT _____

Include all medical bills no matter how small. The total of the bill, even if insurance company, etc. has paid part or all of it, should be included. Ask for a bill when you leave the hospital.

HOSPITAL NAME AND ADDRESS	DOCTORS NAME AND ADDRESS	ADMIT/DISCHARGE FROM	TO	AMOUNT
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____

DOCTOR'S EXPENSES

NAME OF CLIENT _____

Enter each visit to doctor, home visit or hospital call. Enter total amount from doctor bill. Keep parking lot and taxicab receipts. If you use your car, keep round trip mileage.

DATE	MODE OF TRANSPORT	DOCTOR'S NAME AND ADDRESS	TYPE OF TREATMENT	TOTAL BILL
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____

PHYSIOTHERAPY

NAME OF CLIENT _____

Enter all dates on which you have therapy treatments at home or office. Keep all receipts for taxi and parking lot. If you use your car, enter round trip mileage.

DATE	MODE OF TRANSPORT	DOCTOR'S NAME AND ADDRESS	TYPE OF TREATMENT	TOTAL BILL
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____

PRESCRIPTION COSTS

NAME OF CLIENT _____

Enter all prescription and non-prescription drugs, bandages, etc.

DATE	PHARMACY	DOCTOR	DRUG	Rx #	DOSAGE	BILL
_____	_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	_____	\$ _____

MISCELLANEOUS EXPENSES

NAME OF CLIENT _____

Keep all sales receipts for everything that pertains to your case. Enter expenses for ambulance, nurses, domestic help, personal property loss, etc.

DATE	EXPLAIN	AMOUNT
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____