Wellness Journal

A useful tool for the Social Security disability application process

Welcome to your wellness journal, a place to document specific details about your diagnoses, symptoms and treatments. These pages can help you and your doctors better understand your condition—while also informing your current or future Social Security disability case.

No one remembers all of the details of every appointment or conversation. Keeping records that can be referred back to at a later time is vital. Remember, doctors will not record information in your medical records if you do not honestly share symptoms and limitations with them and other treatment professionals.

Sharing and discussing the details you record here with your doctors and other treating providers is important to your treatment as well as the disability application process. Social Security examiners and judges do not know you personally and when weighing your case must rely on information included in your medical records and, if necessary, your testimony.

Having a detailed log of all your experiences leading up to and during your disability application allows both you and Social Security to see a timeline of the symptoms and difficulties you are facing. Your medical records and testimony tell a story, the story of your disabling condition and how it affects you—you want that story to be as accurate as possible.

As you begin using this wellness journal, you might find reviewing the sample journal entries beginning on page 12 useful.

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MEDICATIONS	**DATE:**
Name of medication:	
Prescribing doctor:	Reason taking:
Started:	If stopped, date:
Dose/timing/titration:	
Side effects:	
Name of medication:	
Prescribing doctor:	Reason taking:
Started:	If stopped, date:
Dose/timing/titration:	
Side effects:	
Name of medication:	
Prescribing doctor:	Reason taking:
Started:	If stopped, date:
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Side effects:	
Name of medication:	
Prescribing doctor:	Reason taking:
Started:	If stopped, date:
Dose/timing/titration:	
Side effects:	

MEDICATIONS		**DATE:**
Name of medication:		
Prescribing doctor:	Reason taking:	
Started:	If stopped, date:	
Dose/timing/titration:		
Side effects:		
Name of medication:		
Prescribing doctor:	Reason taking:	
Started:	If stopped, date:	
Dose/timing/titration:		
Side effects:		
Name of medication:		
Prescribing doctor:	Reason taking:	
Started:	If stopped, date:	
Dose/timing/titration:		
Side effects:		
Name of medication:		
Prescribing doctor:	Reason taking:	
Started:	If stopped, date:	
Dose/timing/titration:		
Side effects:		

DAILY EXPERIENCES

Activites of Daily Living (ADLs): ADLs are tasks people need to do everyday for healthy living.

Symptoms:			Date: ❑ Good day ❑ Bad day
ADL (bathing, dressing, toileting, eating, etc.)	**Y/N**	**_____ Mins**	**Adjustments?**
Other ADLs (other things you do daily)	**Y/N**	**_____ Mins**	**Adjustments?**

Symptoms:			Date: ❑ Good day ❑ Bad day
ADL	**Y/N**	**_____ Mins**	**Adjustments?**
Other ADLs (other things you do daily)	**Y/N**	**_____ Mins**	**Adjustments?**

DAILY EXPERIENCES			
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ADL (bathing, dressing, toileting, eating, etc.)	**Y/N**	**____ Mins**	**Adjustments?**
Other ADLs (other things you do daily)	**Y/N**	**____ Mins**	**Adjustments?**

Symptoms:			Date: ❑ Good day ❑ Bad day
ADL	**Y/N**	**____ Mins**	**Adjustments?**
Other ADLs (other things you do daily)	**Y/N**	**____ Mins**	**Adjustments?**

DOCTOR APPOINTMENTS

DATE:

Doctor:	Time:

Test	Reason	Follow up?
		❑ Yes, date:________ ❑ No
		❑ Yes, date:________ ❑ No
		❑ Yes, date:________ ❑ No
		❑ Yes, date:________ ❑ No

Therapy changes (medication, dosage, titration, start/stop):

My to-do list:	Referrals:
❑	
❑	
❑	

Questions:	Answers:
❑ ______________________	1. ______________________
❑ ______________________	2. ______________________
❑ ______________________	3. ______________________
❑ ______________________	4. ______________________

DOCTOR APPOINTMENTS	DATE:

Doctor:	Time:

Test	Reason	Follow up?
		❑ Yes, date:________ ❑ No
		❑ Yes, date:________ ❑ No
		❑ Yes, date:________ ❑ No
		❑ Yes, date:________ ❑ No

Therapy changes (medication, dosage, titration, start/stop):

My to-do list:	Referrals:
❑ ❑ ❑	

Questions:	Answers:
❑ ______________________	1. ______________________
❑ ______________________	2. ______________________
❑ ______________________	3. ______________________
❑ ______________________	4. ______________________

IMPORTANT CONVERSATIONS		DATE:
Organization:	Time:	
Spoke to (name, department, time): 1.	Follow up? ❑ Yes Date: ❑ No Time:	
2.	4.	
3.	5.	
❑ They contacted me. ❑ I contacted them. Reason:		
My next steps: ❑ ____ ❑ ____ ❑ ____	Resources to contact (name, contact info): 1. ____ 2. ____ 3. ____	
Organization:	Time:	
Spoke to (name, department, time): 1.	Follow up? ❑ Yes Date: ❑ No Time:	
2.	4.	
3.	5.	
❑ They contacted me. ❑ I contacted them. Reason:		
My next steps: ❑ ____ ❑ ____ ❑ ____	Resources to contact (name, contact info): 1. ____ 2. ____ 3. ____	

IMPORTANT CONVERSATIONS		DATE:
Organization:	Time:	
Spoke to (name, department, time): 1.	Follow up? ❏ Yes ❏ No	 Date: Time:
2.	4.	
3.	5.	
❏ They contacted me. ❏ I contacted them. Reason:		
My next steps: ❏ ______ ❏ ______ ❏ ______	Resources to contact (name, contact info): 1. ______ 2. ______ 3. ______	
Organization:	Time:	
Spoke to (name, department, time): 1.	Follow up? ❏ Yes ❏ No	 Date: Time:
2.	4.	
3.	5.	
❏ They contacted me. ❏ I contacted them. Reason:		
My next steps: ❏ ______ ❏ ______ ❏ ______	Resources to contact (name, contact info): 1. ______ 2. ______ 3. ______	

APPENDIX A – MEDICATIONS (SAMPLE)	DATE: 3/12/18
Name of medication: Naproxen sodium	
Prescribing doctor: Dr. Arrigoni	Reason taking: High Blood Pressure
Started: 3/12/18	If stopped, date:
Dose/timing/titration:	
Side effects: High blood pressure, Nausea, Dizziness, Headaches	
Name of medication:	
Prescribing doctor:	Reason taking:
Started:	If stopped, date:
Dose/timing/titration:	
Side effects:	
Name of medication:	
Prescribing doctor:	Reason taking:
Started:	If stopped, date:
Dose/timing/titration:	
Side effects:	
Name of medication:	
Prescribing doctor:	Reason taking:
Started:	If stopped, date:
Dose/timing/titration:	
Side effects:	

APPENDIX B – DAILY EXPERIENCES (Sample)

Activites of Daily Living (ADLs): ADLs are tasks people need to do everyday for healthy living.

Symptoms: Severe pain in hands and joints. Shortness of breath. Anxiety			Date: 5/19/18 ❑ Good day ☒ Bad day
ADL (bathing, dressing, toileting, eating, etc.)	**Y/N**	**____ Mins**	**Adjustments?**
Shower and dress	Y	35	Skipped conditioner Used a shower chair
Made lunch for myself	Y	15	Used pre-prepared food in microwave
Other ADLs (other things you do daily)	**Y/N**	**____ Mins**	**Adjustments?**
Retrieved Mail	Y	10	Used slip-on shoes because too painful to bend
Made lunch for myself Laundry Pay Electric Bill	Y N N	15 15 10	Used pre-prepared food in microwave Too painful to carry heavy laundry basket up or down stairs and painful to bend for washer door. Daughter did for me. Too painful to grasp pen to write

Symptoms:			Date: ❑ Good day ❑ Bad day
ADL	**Y/N**	**____Mins**	**Adjustments?**
Other ADLs (other things you do daily)	**Y/N**	**____ Mins**	**Adjustments?**

APPENDIX C – DOCTOR APPTS (Sample)	**DATE:** 7/29/18
Doctor: Dr. Menchuck	Time: 8 am

Test	Reason	Follow up?
Chest X-Ray	Checking lungs for blockage/infection	❑ Yes, date:________ ☒ No
Echocardiogram	Checking heart valves and vessels	☒ Yes, date: 11/3/18 ❑ No
Pulmonary Function Test	Checking on how my lungs are working, like how much air they can hold	☒ Yes, date: 8/27/18 ❑ No
		❑ Yes, date:________ ❑ No

Therapy changes (medication, dosage, titration, start/stop):

Prednisone	New prescription, short supply
ProAir	New prescription

My to-do list:	Referrals:
☒ Pick up new prescription, short supply ❑ Confirm cost and update spending plan to include new prescriptions ❑	

Questions:	Answers:
❑ Is the generic medicine of ProAir the same? The pharmacist mentioned it and said it is less expensive under my insurance	1.
❑ How long will I need to stay on these medicines?	2.
❑	3.
❑	4.

APPENDIX D IMPORTANT CONVERSATIONS (Sample)

DATE: 10/19/18

Organization: MetLife	Time: 2:20pm
Spoke to: (name, dept., time) 1. Janice, Disability, 2:20pm	Follow up? ☒ Yes Date: 10/22/18 ❑ No Time: 9:00 am
2.	4.
3.	5.

☒ They contacted me. ❑ I contacted them.

Reason: Not able to start sending long term disability payments. Missing a form from Dr. Arrigoni. Said I need to apply for Social Security disability.

My next steps:	Resources to contact: (name, contact info)
❑ Call Dr. Arrigoni's office on Tuesday to ask about the form	1. MetLife, Janice - 800-555-9485
❑ Give the fax number and make sure form is sent 'attention' to Janice	2.
❑ Call to see if I can get help with the disability application	3.

Organization:	Time:
Spoke to: (name, dept., time) 1.	Follow up? ❑ Yes Date: ❑ No Time:
2.	4.
3.	5.

❑ They contacted me. ❑ I contacted them.

Reason:

My next steps:	Resources to contact: (name, contact info)
❑	1.
❑	2.
❑	3.