TUCKER™ DISABILITY LAW
We Never Give Up

Daily Capability Journal

Week of (date): _____ Full Name: _____

Column 1: Rate your Pain/Discomfort. This not only refers to physical pain, but to anxiety, depression, and fatigue, as well. Using a scale of 0-10 rate your highest level of pain/discomfort daily.

0-2: - no pain-mild discomfort.

3-5: - pain-that can be treated with medication.

6-9 - you are taking pain medication…it's not working.

10 - your pain is so great you cannot get out of bed.

Column 2: Did you experience any limitations? (Be specific) For example: "I reached into the refrigerator and couldn't even pick up a half-gallon of milk." Or: "I couldn't wash my hair because my shoulder hurt too much."

Column 3: Were you able to go to work? If no, explain why. Example: "I couldn't get out of bed because the medicine I take for my migraine headache makes me to dizzy."

—If you were able to work, were you able to perform 100% of your duties in a satisfactory manner?

—If no, please explain why. For example: "My lower back hurt too much to unload packages." Or "I could only stand for thirty minutes at a time due to my lower back pain forcing another employee having to supervise my line."

	#1	#2	#3
Day	**Pain/ Discomfort**	**Limitations. Y/N Explain**	**Able to Work? Y/N Explain.**
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Sunday			