Documenting Pain for Disability Claims

Complete 6-page guide to creating documentation that supports WorkSafeBC, SSDI, insurance, and government benefit claims — with evidence strength rankings and common denial mistakes.

Start Before You File

Begin tracking immediately. Records that predate your claim are more credible. Even if you're months from filing, daily entries starting now build a stronger case.

Document Functional Impact

Adjusters care most about what pain prevents you from doing. "Couldn't lift laundry basket" is more powerful than "pain was 8/10." Be specific about limitations.

Be Consistent, Not Perfect

Daily brief entries beat weekly detailed ones. If you miss a day, don't backfill — it looks fabricated. Gaps are normal; consistency matters.

Include Good Days

Documenting better days shows honesty. Constant 10/10 ratings destroy credibility. A pattern of mostly difficult days with occasional better ones is believable.

Connect to Work/Function

For WorkSafeBC: connect symptoms to work duties. For disability: describe daily living impact. Every entry should reference real tasks.

Align with Medical Records

Your diary should complement, not contradict, your medical records. Note appointment dates, treatments, and outcomes. Bring diary summaries to appointments.

Evidence Strength Ranking

Disability evaluators weigh evidence differently. Build the strongest possible case by including items from the top tiers.

Strength	Evidence Type	Examples	Your Status
Strongest	Objective medical tests	MRI, X-ray, EMG, bloodwork	
Strong	Specialist medical opinions	Rheumatologist, neurologist letters	
Good	Treatment records + response	Med logs, physio notes, surgery records	
Supporting	Daily pain diary with functional detail	This diary — showing daily limitations	
Helpful	Third-party statements	Employer, family, caregiver letters	

Common Documentation Mistakes That Cause Denials

X Only tracking on bad days
Fix: Looks like you're fine the rest of the time. Track every day.

X Constant 10/10 pain ratings
Fix: Appears exaggerated. Show genuine variation — 3 to 8 is more credible than 8 to 10.

X Starting documentation only after filing
Fix: Pre-filing records are far more credible. Start NOW.

X Contradicting medical records
Fix: If your doctor says "improving" but your diary says "getting worse," evaluators notice.

X Vague descriptions without examples
Fix: "Pain was bad" loses to "Could not carry groceries from car — had to ask neighbor for help."

X Ignoring treatment compliance
Fix: Skipping appointments or not taking prescribed meds weakens any claim.

Name: _____

Date Range: _____

Pain Scale Reference (0–10 NRS)

0 = No Pain 5 = Moderate 10 = Worst Possible

Daily Disability Documentation

Complete daily. Use specific functional language. This page is your primary disability evidence.

Pain level (0-10): _____

Activities I could NOT do today: _____

_____

Activities I completed with difficulty: _____

_____

Assistance needed from others: _____

Self-care limitations: _____

Medications & treatments today: _____

Hours spent lying down/resting: _____

How pain affected my day (use specific, measurable terms)

Functional Impact Assessment

Rate each activity: 0 = Unable, 5 = Significant difficulty, 10 = Full capacity. Use exact numbers — disability evaluators rely on measurable data.

Activity	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Walking (distance before stopping)							
Standing tolerance (minutes)							
Sitting tolerance (minutes)							
Lifting capacity (lbs)							
Bending / stooping							
Reaching / overhead work							
Gripping / fine motor							
Stair climbing							
Concentration / focus							
Driving							

Self-Care & Daily Living

Mark: Y = Independent ~ = Modified / used aids X = Unable H = Needed help from another person.

Activity	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Bathing (with/without aids)							
Dressing upper + lower body							
Preparing a meal							
Housework (duration)							
Shopping (distance walked)							
Driving (continuous min)							
Hours resting/lying down							

Evidence of Functional Decline (specific examples for claims)

Disability Documentation Checklist

Check off each item as you complete it. A fully checked list means your claim has strong documentation.

- [ ] Consistent daily pain diary (30+ days minimum)
- [ ] Functional impact documented for each day
- [ ] Both good AND bad days recorded
- [ ] Medication log with response tracking
- [ ] Treatment compliance documented (appointments attended)
- [ ] Medical appointment dates and outcomes noted
- [ ] Specific activities affected (not just pain ratings)
- [ ] Third-party statements requested (family, employer)
- [ ] Imaging and test results organized
- [ ] Weekly summary prepared for adjudicator review
- [ ] Timeline from injury/onset to present documented
- [ ] Work impact (hours missed, duties impossible) logged

Documentation Timeline

Phase	When	Action	Status
NOW	Today	Start daily pain diary	
Week 1-2	First 2 weeks	Establish baseline data	
Week 3-4	Month 1	Request medical records + specialist letters	
Month 2	Before filing	Compile evidence package + weekly summaries	
Filing	Day of	Submit copies only — keep originals safe	
Ongoing	After filing	Continue tracking; attend all appointments	

Weekly Summary — Disability Documentation

Complete weekly. Disability adjudicators prioritize consistency. A 30-day diary with weekly summaries is the minimum evidence standard.

Week of: _____

Average Pain Level (0-10): _____

Worst Day (date + level): _____

Best Day (date + level): _____

Flare Days This Week: _____

Sleep Quality Average (1-5): _____

Days unable to work this week: _____

Medical appointments attended: _____

Treatment compliance (%): _____

Pattern Observations

Functional decline compared to last week: _____

Medical evidence gathered this week: _____

Third-party observations (family, coworkers): _____

Activities that prove functional limitation: _____

Questions for Next Appointment

1. _____
2. _____
3. _____
4. _____
5. _____

Claim-Specific Documentation Gaps to Address