You Found Something That Actually Helps.

If you've ever left an appointment feeling like you didn't say what you meant — or like what you said didn't make it into your chart — this kit is for you.

If you've ever had to choose between explaining your worst days and not looking 'too sick' — this kit is for you.

If you're tired of carrying your entire medical history in your head every time you walk through a clinic door — this kit is for you.

What's inside this kit

- **Appointment Prep Card**
  A one-page form you fill out in 60 seconds. Bring it to any appointment or send it ahead.
- **HERO Form Lite**
  A structured one-pager for fuller appointments — History, Experiences, Requests, Outcomes.
- **Disability-Safe Documentation Guide**
  How to track and describe your symptoms in ways that matter for disability, insurance, and treatment decisions — plus scripts you can say out loud to your provider.

How to use this kit

Before your appointment → Fill out the Appointment Prep Card or the HERO Form.

During your appointment → Hand it to your provider or read from it. Use the scripts on page 5.

After your appointment → Complete the 'Outcomes' section. File it. That note is now part of your record.

Ongoing → Use the Documentation Guide to build a consistent symptom trail over time.

Documentation is protection.

Your records are your evidence. This kit helps you build them — clearly, consistently, and in language the system is designed to respond to.

You are not imagining this. Your experience deserves to be in the record.
This kit exists to help make sure it is.

More tools, videos, and guides at thedocumentedpatient.com

Which tool is right for right now?

You don't have to use every page every time. Use what fits your energy and your appointment.

I have 60 seconds or I'm already in the waiting room.

Use the Appointment Prep Card (page 3)

Fill in your top 2 symptoms, your #1 impact, and your #1 question.
Hand it to your provider or read from it. That's it. That's enough.

I have 10-15 minutes and want to prepare more fully.

Use the HERO Form Lite (page 4)

Walk through History, Experiences, Requests, and Outcomes.
Bring it in. It gives your provider a clear picture before you say a word.

I want to build a record that protects me over time.

Use the Disability-Safe Documentation Guide (page 5)

Learn what to track, how to say it, and what language the system actually responds to. Use the scripts. Keep the record.

On a bad day, even one filled-in field is documentation. Any record is better than none.

Not sure what to write? The Disability-Safe Documentation Guide has scripts you can read word for word.

Appointment Prep Card (60 seconds)

Bring this page to your appointment or send it in advance.

Section 1 — Today's Top 2 Symptoms

Symptom #1: _____

What changed? _____ When did it start / worsen? _____

Frequency: _____ Severity (1–10): ____

Symptom #2: _____

What changed? _____ When did it start / worsen? _____

Frequency: _____ Severity (1–10): ____

Section 2 — Top 1 Impact (what this interrupts)

- ☐ basic daily tasks
- ☐ walking/balance
- ☐ sleep
- ☐ driving
- ☐ concentration/memory
- ☐ pain tolerance
- ☐ endurance
- ☐ work-like tasks
- ☐ other: _____

One-sentence impact statement: " _____ **"**

Section 3 — Top 1 Question I Need Answered

" _____ ?"

Section 4 — Top 1 Next Step I'm Asking For

- ☐ test/lab/imaging
- ☐ referral
- ☐ medication adjustment
- ☐ therapy/rehab
- ☐ accommodation note
- ☐ other: _____

My requested next step: _____

Section 5 — Medication / Side Effect Note (optional)

Current med(s) / changes: _____

Side effects / issues: _____

Documentation Request (calm + direct)

"Would you please document my symptoms and functional limits in the chart today, including how they affect my day-to-day and ability to sustain work-like activities?"

After the visit — what was decided?

Diagnosis / plan: _____

Follow-up date / next step: _____

HERO Form Lite (Printable One-Pager)

HERO = History • Experiences • Requests • Outcomes

H History

Reason for visit: _____

What changed / when it started: _____

Symptoms (frequency, duration, triggers, relief):

_____

_____

Relevant history (diagnoses, procedures, major events):

_____

E Experiences

How this affects my daily life (specific examples):

_____

_____

Work-like impact (reliability, pace, breaks, attendance):

_____

What I've tried / what helped / what didn't:

_____

R Requests (for today)

- ☐ Please document diagnosis(es) and functional limits clearly
- ☐ Consider tests/imaging/labs: _____
- ☐ Consider referral(s): _____
- ☐ Treatment plan options: _____
- ☐ Work/school accommodations (if needed): _____

My top 3 questions:

1) _____

2) _____

3) _____

O Outcomes (fill in after visit)

Provider's plan / recommendations:

_____

_____

Tests/referrals ordered: _____

Medication changes (dose/side effects to watch):

_____

_____

Follow-up date + what we're monitoring:

_____

Disability-Safe Documentation Guide

How to protect your record and advocate clearly (without becoming overwhelmed).

What matters most in documentation

Many medical records capture diagnosis names. Disability decisions and treatment planning often depend on functional impact and consistency over time. Focus on documenting:

1. **Frequency & duration**— how often, how long, and fluctuation.
2. **Severity with examples**— numbers plus real-life examples.
3. **Functional limits**— what you can't do safely or consistently.
4. **Variability over time**— good days + bad days, persistent pattern.
5. **Treatment tried + response**— what helped, what didn't, side effects, barriers.
6. **Work-like task impact**— reliability, pace, persistence, attendance.

What to say at appointments (scripts)

— *"Would you please document my symptoms and functional limits in the chart today?"*

— *"Could you note how this affects my day-to-day tasks and ability to sustain work-like activities?"*

— *"I can sometimes do this once, but I can't do it consistently or safely."*

— *"If this doesn't improve in X weeks, what's our plan B?"*

— *"I'm not asking for a specific answer — I'm asking that we document what's happening and what we're doing next."*

What records to keep at home (simple system)

You don't need a perfect binder. You need consistency.

- Symptom tracker (daily or a few times/week)
- Medication + side effect log (changes + reactions)
- Appointments & outcomes (what was decided, tests, referrals)
- Evidence folder (labs, imaging summaries, discharge papers, letters)

2-minute format: Date → Symptom → Severity → Impact → What helped → What's next

Tracking tips that actually help

- Track measurable limits: minutes standing, breaks, missed days, recovery time, cognitive errors, falls, driving limits.
- Use consistent language and add context to better days.

You're not done — you're just getting started.

This kit is the beginning. Here's where to go next.

Watch the Videos

Our YouTube channel walks you through how to document
symptoms, prepare for appointments, and advocate
clearly — even on hard days.

Search: The Documented Patient

Read the Substack

Honest writing about navigating broken systems — what patients wish they knew sooner, and tools you can actually use.

thedocumentedpatient.substack.com

More tools are coming.

Deeper symptom tracking guides. Denial and appeal documentation tools.
Prior authorization support. Caregiver resources. Expanded templates.
Join the email list at thedocumentedpatient.com to get them first.

Documentation is protection.

The more consistently you document, the harder it becomes for the system to overlook you.

This kit was built by a patient, for patients. If it helps you feel more prepared, more organized, or even just a little less alone in this — that's the whole point.

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