IBS & BOWEL-MOVEMENT LOG

VETERAN INFORMATION AND BASELINE

Veteran Advocacy Group LLC | VA Accredited Claims Agent

Accreditation #60676 | POA Code KW9 | 272-257-1349 | claims@veteran-advocacy.com | www.veteran-advocacy-group.com

VETERAN INFORMATION

Veteran name	VA file number (last 4 only)	Log start date

Primary phone	Email	Representative / provider

CONDITION BASELINE

Diagnosis, if known	Treating provider	Typical bowel pattern

Date symptoms began	Typical frequency	Typical severity (0-10)

CURRENT TREATMENT

Medication / diet treatment	Frequency	Benefit	Side effects

HOW TO USE THIS LOG

Record symptoms as soon as practical. Include frequency, severity, duration, treatment, and what the condition prevented or made difficult. Describe effects on employment, relationships, sleep, mobility, self-care, driving, and household activities. Record only events and limitations actually experienced. Keep related medical and employment records. Seek medical care for blood in stool, black stool, fainting, severe dehydration, or severe persistent abdominal pain.

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SEVEN-DAY SYMPTOM AND FUNCTIONAL-IMPACT SUMMARY

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Veteran name	Week beginning	Week ending

DAILY SUMMARY

Date	Bowel movements	Type / urgency	Pain 0-10	Accident	Treatment	Work / daily impact

WEEKLY FUNCTIONAL IMPACT

Total episodes / symptom days	Severe symptom days	Care or treatment contacts

Work hours lost	Appointments / activities missed	Help needed from another person

Weekly notes, patterns, triggers, or changes:

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DETAILED SYMPTOM OR EPISODE RECORD

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Veteran name _____

Date _____

Condition / affected area _____

SYMPTOM OR EPISODE DETAILS

[ ] Diarrhea [ ] Constipation [ ] Alternating pattern [ ] Abdominal pain [ ] Bloating [ ] Urgency

[ ] Accident / leakage [ ] Incomplete emptying

Episode start / end _____

Number and type of stools _____

Pain / bloating / urgency _____

Food or possible trigger _____

Medication / relief _____

TREATMENT, RESPONSE & WITNESSES

Restroom access / accident _____

Work / travel / activity impact _____

Medication / treatment used _____

Relief: none / partial / complete _____

Time until recovery _____

FUNCTIONAL IMPACT

[ ] Continued normally [ ] Reduced activity [ ] Stopped activity [ ] Needed rest

[ ] Needed assistance [ ] Missed work [ ] Left early [ ] Missed appointment

Work or activity time lost _____

Person who observed / assisted _____

Provider contacted _____

Describe exactly what the symptoms prevented, interrupted, or required help completing:

_____

_____

_____

_____