HEADACHE DIARY

Name of Patient :_____

DATE:				
Time headache began				
Time headache ended				
Warning signs (aura)				
Location of pain				
Type of pain:(pressing, piercing, throbbing, etc.)				
Intensity of pain: Circle one number at right.	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10
Other symptoms : (nausea, vomiting)				
Medication taken / other treatment				
Effect of treatment				
How headache affected my normal routine				
Hours of sleep the night before the headache				
What I ate before the headache: (caffeine, diet soda, chocolate, hot dogs, food with artificial sweeteners, processed foods)				
Activities before the headache occurred				
Important or stressful events that occurred today				
Comments				