

Name: _____ Month: _____ Year: _____

DATE		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
<i>Headache Severity</i>	Morning																															
	Afternoon																															
	Evening/Night																															

Scale of 0-10 No pain = 0 1 2 3 4 5 6 7 8 9 10 = Pain as bad as it could be

SYMPTOMATIC MEDICATIONS (Tablets/injections per day) (Medications taken to treat a headache eg. Triptans, painkillers, etc.)

Name: _____ / _____ mg																															
Overall relief																															
Name: _____ / _____ mg																															
Overall relief																															
Name: _____ / _____ mg																															
Overall relief																															
Name: _____ / _____ mg																															
Overall relief																															

Relief: 0-1-2-3 0 = None 1 = Slight Relief 2 = Moderate Relief 3 = Complete Relief

PREVENTATIVE MEDICATIONS (Daily medications taken to prevent or decrease your headache tendency eg. Amitriptyline)

Name: _____ / _____ mg																														
Name: _____ / _____ mg																														

MENSTRUAL PERIODS	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

DISABILITY FOR THE DAY	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

0 = None 1 = Able to carry out usual activities fairly well 2 = Difficulty with usual activity, may cancel less important ones 3 = Have to miss work (all or part of day) or go to bed for part of day

TRIGGERS	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Please code trigger with a number and give details below. Record trigger number in table above on the appropriate date where you feel that trigger contributed to your headache.

1 _____ 2 _____ 3 _____ 4. _____

(Please turn page over and complete the other side)

For your headache treatment, please record here any physician visits, emergency room visits, hospitalization, or visits to any other health practitioners (naturopaths, chiropractors, etc.):

Date	Who/Place	Date	Who/Place

Please list any costs you have incurred through purchase of vitamins, herbs, etc or any headache treatment compounds not listed on your diary as medications:
