

Headache Diary

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
Headache Severity	Morning																															
	Afternoon																															
	Evening/Night																															
		Scale of 0-10							No pain = 0							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.

