# Headache Diary Instructions and Sample

**(Do not write on this sheet)**

**HNC-CHR Website**

**The information you enter into this diary can be very helpful for you and your doctor.** Please complete your diary on a daily basis. Each diary sheet is for one month, and there is a column for each day of the month. To record headache severity, each day is divided into three sections.

**Headache Severity:** Please grade your headaches from 0 to 10 (scale shown below) to tell us how severe your headache was. Even if you are headache free, indicate this using a "0". Please see the attached sheet for a guideline to determine your headache severity. (Example shown below)

| | 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 | 0 | 0 | 0 | **2** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **1** | 0 | 0 | **5** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | Afternoon | 0 | 0 | 0 | **4** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **4** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | Evening/Night | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **4** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **1** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

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 Medication:** Place the names of the symptomatic medications you take in the blank space on the left hand side. Put the number of tablets/ injections per day which you take of each medication in the box under the correct date. Below the box which indicates the number of tablets taken, indicate how well that medication worked for you that day by placing a number, 0 to 3 (Relief Code).

**SYMPTOMATIC MEDICATIONS (Tablets/injections per day) (Medications taken to treat a headache) (Example shown below)**

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Name: **Ibuprofen / 200 mg** | | | | 2 | | | | | | | 2 | | | | | | | | | 3 | | | | | | | | | | | | |
| Overall relief | | | | 3 | | | | | | | 2 | | | | | | | | | 2 | | | | | | | | | | | | |

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

**Preventative Medication:** If you are taking a preventative medication daily for your headache, enter the name and dosage in the blank space on the left hand side, and fill in the number of tablets taken each day.

**PREVENTATIVE MEDICATIONS (Daily medications taken to prevent or decrease your headache tendency) (Example shown below)**

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Name: **Amitriptyline/10 mg** | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 |

**Menstrual Period:** Place an X under the correct dates to indicate on the days you have your menstrual period.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **MENSTRUAL PERIODS** | | | | | | | | | | | | | | | | | | | | X | X | X | X | | | | | | | | | |

**Disability for the Day:** Please grade the amount of disability you experienced from 0 to 3 (scale shown below). Write the number in the appropriate square for each day.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **DISABILITY FOR THE DAY** | | | | 1 | | | | | | | 1 | | | | | 0 | | | | 2 | | | | | | | | | | | | |

**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 | | | | | | | | | | | | |

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** Red Wine **2** Menstrual period **3** _____ **4.** _____