

HEADACHE DIARY

Date:	Date:	Date:	Date:
Warning Signs:	Warning Signs:	Warning Signs:	Warning Signs:
Time Begun:	Time Begun:	Time Begun:	Time Begun:
Time Ended:	Time Ended:	Time Ended:	Time Ended:
Type of Pain: (e.g., piercing, throbbing, etc.)	Type of Pain: (e.g., piercing, throbbing, etc.)	Type of Pain: (e.g., piercing, throbbing, etc.)	Type of Pain: (e.g., piercing, throbbing, etc.)
Intensity of Pain: (circle one) (L) 1 2 3 4 5 6 7 8 9 (H)	Intensity of Pain: (circle one) (L) 1 2 3 4 5 6 7 8 9 (H)	Intensity of Pain: (circle one) (L) 1 2 3 4 5 6 7 8 9 (H)	Intensity of Pain: (circle one) (L) 1 2 3 4 5 6 7 8 9 (H)
Location: (e.g., between eyes, back of head, etc.)	Location: (e.g., between eyes, back of head, etc.)	Location: (e.g., between eyes, back of head, etc.)	Location: (e.g., between eyes, back of head, etc.)
Treatment or Medication Taken:	Treatment or Medication Taken:	Treatment or Medication Taken:	Treatment or Medication Taken:
Effect of Treatment:	Effect of Treatment:	Effect of Treatment:	Effect of Treatment:
Hours of Sleep:	Hours of Sleep:	Hours of Sleep:	Hours of Sleep:
What I Ate Today:	What I Ate Today:	What I Ate Today:	What I Ate Today:
Events Prior to Headache: (e.g., strenuous activity, elevated stress, etc.)	Events Prior to Headache: (e.g., strenuous activity, elevated stress, etc.)	Events Prior to Headache: (e.g., strenuous activity, elevated stress, etc.)	Events Prior to Headache: (e.g., strenuous activity, elevated stress, etc.)
Comments:	Comments:	Comments:	Comments: