

7-DAY HEADACHE DIARY

Name: _____

Daily headache information helps your health care providers to diagnose your headaches correctly.
Check the boxes by the topic that applied to each day.

Write your preventive or acute medications, measures, or devices: Tx 1: _____
Tx 3: _____ Tx 4: _____

Tx 2: _____
Tx 5: _____

*This form can be printed and filled in manually, or
completed on a computer. Save the file for future use.*

Date	Preventive Treatment	Acute Treatment	Warning Signs	Headache	Other Symptoms	Lifestyle	Behavior & Self-Management
	<input type="checkbox"/> Medication <input type="checkbox"/> Device <input type="checkbox"/> Behaviors & Self-Management Notes:	Medication Tx #: _____ Time: _____ Dose: _____ Device Tx #: _____ Time: _____ Therapy Tx #: _____ Time: _____	<input type="checkbox"/> Aura Other:	Pain (0-10): _____ Start time: _____ End time: _____ Notes:	Sensitive to: <input type="checkbox"/> Light <input type="checkbox"/> Sound <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Worse with activity	Stress (0-10): _____ Hours slept: _____ <input type="checkbox"/> Physically active <input type="checkbox"/> Hydration	Headache interference (0-10): _____ Sleep quality: _____ <input type="checkbox"/> Skipped meal <input type="checkbox"/> Caffeine
	<input type="checkbox"/> Medication <input type="checkbox"/> Device <input type="checkbox"/> Behaviors & Self-Management Notes:	Medication Tx #: _____ Time: _____ Dose: _____ Device Tx #: _____ Time: _____ Therapy Tx #: _____ Time: _____	<input type="checkbox"/> Aura Other:	Pain (0-10): _____ Start time: _____ End time: _____ Notes:	Sensitive to: <input type="checkbox"/> Light <input type="checkbox"/> Sound <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Worse with activity	Stress (0-10): _____ Hours slept: _____ <input type="checkbox"/> Physically active <input type="checkbox"/> Hydration	Headache interference (0-10): _____ Sleep quality: _____ <input type="checkbox"/> Skipped meal <input type="checkbox"/> Caffeine
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