7-DAY HEADACHE DIARY

This form can be printed and filled in manually, or completed on a computer. Write down your headache information DAILY to share with your health care providers to help them diagnose your headaches correctly. Check the boxes of the topic that apply to you each day.

Name: ____ Prophylaxis: ____

Clear Button

Date	Prevention	Headache	Symptoms	Warning Signs	Medication / Device	Lifestyle	Behavioral Coping
	☐ Medication ☐ Device ☐ Behaviors	Pain (0-10): ______ Start time: ______ End time: ______	Sensitive to: ☐ Light ☐ Sound ☐ Nausea ☐ Vomiting ☐ Worse with activity	Aura	Medication: __________ Time: _____ Dose: _____ Device: ___________ Time: ____________	Stress (0-10): ____ Headache interference (0-10): ____ Hours slept: _____ Sleep quality: __________ ☐ Physically active ☐ Skipped meal ☐ Hydration ☐ Caffeine	
	☐ Medication ☐ Device ☐ Behaviors	Pain (0-10): ______ Start time: ______ End time: ______	Sensitive to: ☐ Light ☐ Sound ☐ Nausea ☐ Vomiting ☐ Worse with activity	Aura	Medication: __________ Time: _____ Dose: _____ Device: ___________ Time: ____________	Stress (0-10): ____ Headache interference (0-10): ____ Hours slept: _____ Sleep quality: __________ ☐ Physically active ☐ Skipped meal ☐ Hydration ☐ Caffeine	
	☐ Medication ☐ Device ☐ Behaviors	Pain (0-10): ______ Start time: ______ End time: ______	Sensitive to: ☐ Light ☐ Sound ☐ Nausea ☐ Vomiting ☐ Worse with activity	Aura	Medication: __________ Time: _____ Dose: _____ Device: ___________ Time: ____________	Stress (0-10): ____ Headache interference (0-10): ____ Hours slept: _____ Sleep quality: __________ ☐ Physically active ☐ Skipped meal ☐ Hydration ☐ Caffeine	
	☐ Medication ☐ Device ☐ Behaviors	Pain (0-10): ______ Start time: ______ End time: ______	Sensitive to: ☐ Light ☐ Sound ☐ Nausea ☐ Vomiting ☐ Worse with activity	Aura	Medication: __________ Time: _____ Dose: _____ Device: ___________ Time: ____________	Stress (0-10): ____ Headache interference (0-10): ____ Hours slept: _____ Sleep quality: __________ ☐ Physically active ☐ Skipped meal ☐ Hydration ☐ Caffeine	
	☐ Medication ☐ Device ☐ Behaviors	Pain (0-10): ______ Start time: ______ End time: ______	Sensitive to: ☐ Light ☐ Sound ☐ Nausea ☐ Vomiting ☐ Worse with activity	Aura	Medication: __________ Time: _____ Dose: _____ Device: ___________ Time: ____________	Stress (0-10): ____ Headache interference (0-10): ____ Hours slept: _____ Sleep quality: __________ ☐ Physically active ☐ Skipped meal ☐ Hydration ☐ Caffeine	
	☐ Medication ☐ Device ☐ Behaviors	Pain (0-10): ______ Start time: ______ End time: ______	Sensitive to: ☐ Light ☐ Sound ☐ Nausea ☐ Vomiting ☐ Worse with activity	Aura	Medication: __________ Time: _____ Dose: _____ Device: ___________ Time: ____________	Stress (0-10): ____ Headache interference (0-10): ____ Hours slept: _____ Sleep quality: __________ ☐ Physically active ☐ Skipped meal ☐ Hydration ☐ Caffeine	
	☐ Medication ☐ Device ☐ Behaviors	Pain (0-10): ______ Start time: ______ End time: ______	Sensitive to: ☐ Light ☐ Sound ☐ Nausea ☐ Vomiting ☐ Worse with activity	Aura	Medication: __________ Time: _____ Dose: _____ Device: ___________ Time: ____________	Stress (0-10): ____ Headache interference (0-10): ____ Hours slept: _____ Sleep quality: __________ ☐ Physically active ☐ Skipped meal ☐ Hydration ☐ Caffeine	

VA/DOD Clinical Practice Guideline for Primary Care Management of Headache. For more information, https://www.healthquality.va.gov/guidelines/pain/headache/VADoDHeadacheCPGPatientSummaryFinal508.pdf