Name: _____ Birthdate: _____ Month:_____

Part 1: Headache Severity

(0=no pain: 10=the worst pain you have experienced)

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
Morning																															
Afternoon																															
Evening																															

Part 2: Headache Duration

(Mark with an "**X**" how long each headache)

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
<4 hours																															
4-12 hours																															
13-24 hours hours																															

Part 3: Headache Symptoms

(Mark with an "**X**" any signs or symptoms experienced with each headache)

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
Aura																															
Nausea																															
Sensitivity to light																															
Sensitivity to sound																															
Inability to work/function																															
Throbbing																															
1)																															
2)																															
3)																															

Part 4: Medications Used:

(Record the name and dose of medication used and placing an "**X**" on the day used)

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
Medication #1 name: _____																															
Dosage per day: _____																															
Medication #2 name: _____																															
Dosage per day: _____																															
Medication #3 name: _____																															
Dosage per day: _____																															
Physio, Chiro, Massage _____																															
Other _____																															