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:

This headache diary is to help you evaluate and characterize your headache, and identify treatment options that work for you. Please discuss the information recorded in the headache diary with your doctor, as well as available treatment options that would be appropriate for you.