Headache Diary

Name: _____

Age: _____

Date: _____

Log Number: 01

Headache Occurences

Date: _____

Time Started: _____

Time Ended: _____

Description:

Intensity of Pain

- ☐ **Mild**
- ☐ **Moderate**
- ☐ **Severe**

Location

- ☐ **Front**
- ☐ **Back**
- ☐ **Left Side**
- ☐ **Right Side**
- ☐ **All Over**

Symptoms Accompanying Headache

- ☐ **Nausea**
- ☐ **Vomiting**
- ☐ **Light Sensitivity**
- ☐ **Sound Sensitivity**
- ☐ **Dizziness**
- ☐ **Blurry Vision**

- [ ] Others: _____

Potential Triggers

- [ ] Lack of Sleep
- [ ] Stress
- [ ] Missed Meal
- [ ] Alcohol Consumption
- [ ] Caffeine Consumption
- [ ] Weather Changes
- [ ] Others: _____

Medication Taken, Time, and Dosage

Relief

- [ ] Complete
- [ ] Partial
- [ ] None

Additional Notes, Observations, and Recommendations

Log Number: _____

Headache Occurences

Date: _____

Time Started: _____

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- ☐ **Dizziness**
- ☐ **Blurry Vision**
- ☐ **Others: _____**

Potential Triggers

- ☐ **Lack of Sleep**
- ☐ **Stress**

- [ ] Missed Meal
- [ ] Alcohol Consumption
- [ ] Caffeine Consumption
- [ ] Weather Changes
- [ ] Others: _____

Medication Taken, Time, and Dosage

Relief

- [ ] Complete
- [ ] Partial
- [ ] None

Additional Notes, Observations, and Recommendations