

Headache diary

Feel free to print multiple copies of this diary for your personal use.

	FIRST EPISODE	SECOND EPISODE	THIRD EPISODE
Date/day of the week of headache			
Time of onset			
Time of resolution			
Warning signs			
Location(s) of the pain			
Type of pain			
Intensity of the pain *			
Additional symptoms			
Activities/circumstances at time of onset			
Time of most recent meal prior to onset			
Food/drink most recently consumed prior to onset			
Medication(s) taken for headache			
Response to medication(s)			
Other action(s) taken for relief			
Response to action(s)			
Last menstrual period **			
Medication(s) currently taken for other condition(s)			

* On a scale from 1 to 10, with 10 being the worst pain possible

** Beginning date and ending date