Headache Diary

Head-ache	Date:	Time Started:	Time Ended:
	Warning Signs:		
Pain	Type of Pain: (e.g. piercing, throbbing, etc)		
	Intensity of Pain: (circle one) (Low) 1 2 3 4 5 6 7 8 9 (High)		
	Location: (e.g. between eyes, back of head, etc)		
Treatment	Treatment or Medication Taken:		
	Effect of Treatment:		
Circumstances	Hours of Sleep:		
	What I ate today:		
	Events prior to headache: (e.g. strenuous activity, elevated stress, etc)		
Comments: ***weather, day of menstrual cycle , occurred using washroom, issues at home/work/school, social activities etc.***			

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