Patient Name: _____

DOB: _____

Headache Diary

	Date: _____	Date: _____	Date: _____	Date: _____	Date: _____	Date: _____
Start and end time of headache	Start: _____ End: _____	Start: _____ End: _____	Start: _____ End: _____	Start: _____ End: _____	Start: _____ End: _____	Start: _____ End: _____
Type of pain (pressure-like, sharp, throbbing, dull)						
Location of pain (back, forehead, temples, around eyes, all over)						
Intensity of pain (circle one)	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
List foods/drinks in last 8 hours						
Other symptoms? (light or noise sensitivity, nausea, vomiting)						
Anything make headache worse?						
Anything make headache better? (Rest, darkness, medication)						
How many hours slept last night?						