



## Use this diary to track details of your headaches.

You can share this information with your doctor when talking about your condition and treatment plan.

### Instructions

#### Part 1: Headache severity

Record the strength of your headache pain using an 11-point scale, where 0 = *no pain* and 10 = *the worst pain you have experienced*. Provide scores for different times of the day—morning, afternoon, and evening—to see how your headache pain changes.

#### Part 2: Headache duration

Record how long your headaches last: less than 4 hours, 4 to 12 hours, or 13 to 24 hours.

#### Part 3: Headache symptoms

Record all symptoms that accompany each headache. Choose from the list provided, or list any other symptoms in the space(s) noted "Other."

#### Part 4: Medication use

Record the name and dose of medication used, if any. This includes all acute and preventive medications, both over-the-counter and prescription.

Name \_\_\_\_\_ Month/Date \_\_\_\_\_



**Part 1: Headache severity** (0 = no pain; 10 = the worst pain you have experienced)

Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
Morning																																
Afternoon																																
Evening																																

**Part 2: Headache duration** (Mark with an "X" how long each headache lasted)

Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Less than 4 hours																															
4 to 12 hours																															
13 to 24 hours																															

**Part 3: Headache symptoms** (Mark with an "X" any signs or symptoms experienced with each headache)

Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Aura																															
Nausea																															
Sensitivity to light																															
Sensitivity to sound																															
Inability to work/function																															
Throbbing																															
Other:																															
Other:																															
Other:																															

**Part 4: Medication use** (Record the name and dose of medication used, if any)

Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Medication 1 name:																															
Dosage per day																															
Medication 2 name:																															
Dosage per day																															
Medication 3 name:																															
Dosage per day																															
Medication 4 name:																															
Dosage per day																															

Adapted from the American Headache Society.