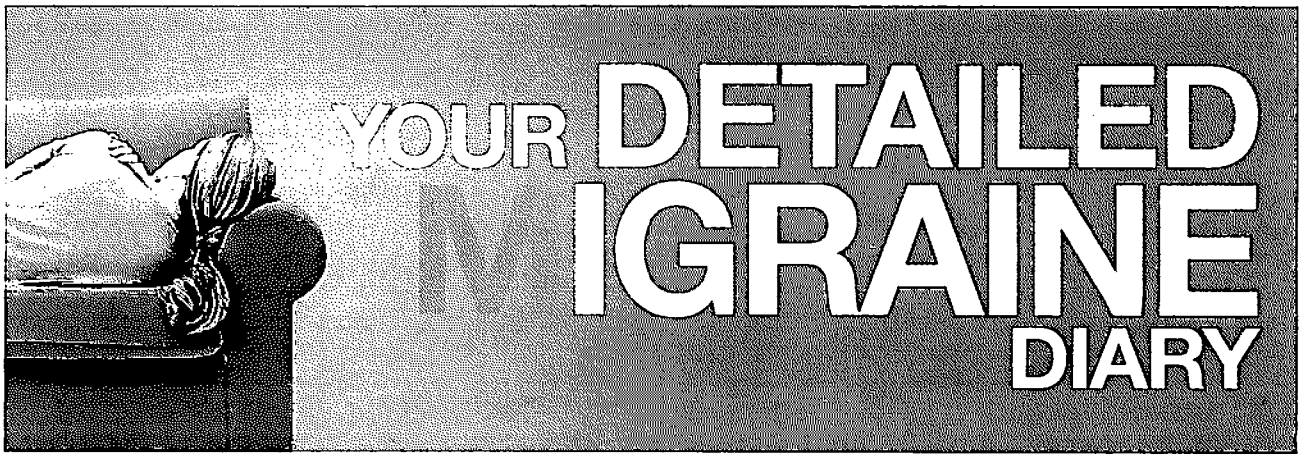
Name _____ Month/Date _____



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.

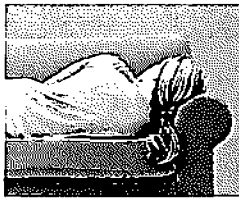
Part 3: **Headache symptoms**

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 _____



DETAILED MANAGEMENT DIARY

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.