HEADACHE DIARY **Patient Name:**

	DATE	HEADACHE START TIME	HEADACHE STOP TIME	LOCATION	SEVERITY (0-3 SCALE)	LIST ASSOCIATED SYMPTOMS	DISABILITY SCALE	MEDICINE	EFFECT	SIDE EFFECTS
					0=None 1=Mild 2=Moderate 3=Severe	0=None 1=Nausea 2=Vomiting 3=Photophobia 4=Phonophobia 5=Dizzy	0=None 1=Mild 2=Moderate 3=Severe		Improvement Scale 0-5	
SUN										
MON										
TUES										
WED										
THURS										
FRI										
SAT										