HEADACHE DIARY INSTRUCTIONS:

If you have a Headache on a given day, rate your pain on a scale of 1(mild) – 10(severe), and indicate how much of each abortive medicine you took as well as the time to relief. Record the exact dates you start, stop, or change the dosage of daily medications.

September 2014

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
	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				

HEADACHE DIARY INSTRUCTIONS:

If you have a Headache on a given day, rate your pain on a scale of 1(mild) – 10(severe), and indicate how much of each abortive medicine you took as well as the time to relief. Record the exact dates you start, stop, or change the dosage of daily medications.

October 2014

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
			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	

This is a ONE MONTH log. One page holds all 30-31 days. Fill in your headache information the day after you have a headache**. Bring these forms to your next visit** and give them to the nurse before the doctor sees you. **PLEASE WRITE YOUR NAME ON EACH PAGE.** _____

HEADACHE DIARY INSTRUCTIONS:

If you have a Headache on a given day, rate your pain on a scale of 1(mild) – 10(severe), and indicate how much of each abortive medicine you took as well as the time to relief. Record the exact dates you start, stop, or change the dosage of daily medications.

November 2014

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
						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						

This is a ONE MONTH log. One page holds all 30-31 days. Fill in your headache information the day after you have a headache**. Bring these forms to your next visit** and give them to the nurse before the doctor sees you. **PLEASE WRITE YOUR NAME ON <u>EACH</u> PAGE.** _____

HEADACHE DIARY INSTRUCTIONS:

If you have a Headache on a given day, rate your pain on a scale of 1(mild) – 10(severe), and indicate how much of each abortive medicine you took as well as the time to relief. Record the exact dates you start, stop, or change the dosage of daily medications.

December 2014

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
	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			

This is a ONE MONTH log. One page holds all 30-31 days. Fill in your headache information the day after you have a headache**. Bring these forms to your next visit** and give them to the nurse before the doctor sees you. **PLEASE WRITE YOUR NAME ON EACH PAGE.** _____