HEADACHE CALENDAR

Name:_____ **Month:**_____ **Year:**_____

1=Mild (bothersome, does not inhibit work or other activities) 2= Moderate (limits activities, impairs normal function) 3=Severe (incapacitating, bed rest required)

Time/Date	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																															
Sleep Time																															
HA Duration (hours)																															

Associated Symptoms

B = Before ✓ = During A= After the headache

Light Sensitivity																															
Noise Sensitivity																															
Nausea																															
Vomiting																															
Worse with Movement																															
Blurred Vision																															
Dizziness																															
Menstrual Period																															

Medication & Relief

0 = None; 10 = Minimal Relief (10%); 25 = 25% Relief; 50 = 50% Relief; 75 = 75% Relief; 100 = Complete Relief (100%)

Relief ⇨																															
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