HEADACHE DIARY

Start date of pain: ----------

Family history of headaches? Yes/No

Interrupt normal activities? Yes/No

Location/Does it move? Yes/No

Constant?/Come and go? Yes/No

Known stressors? Yes/No

Day of Week and Date	Time(s)	Severity* 0 - 10	Where? Home/School	Sharp/Throb Dull/Squeeze	Anything Make Better?	Any Other Symptoms?	Wake from Sleep?

Patient Name: _____ DOB: _____

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