7-DAY HEADACHE DIARY

Name: ______________________________

Daily headache information helps your health care providers to diagnose your headaches correctly. Check the boxes by the topic that applied to each day.

Clear Button

Write your preventive or acute medications, measures, or devices: Tx 1: ______________________________ Tx 2: ______________________________

Tx 3: ______________________________ Tx 4: ______________________________ Tx 5: ______________________________

This form can be printed and filled in manually, or completed on a computer. Save the file for future use.

Date	Preventive Treatment	Acute Treatment	Warning Signs	Headache	Other Symptoms	Lifestyle	Behavior & Self-Management
	☐ Medication ☐ Device ☐ Behaviors & Self-Management Notes:	Medication Tx #: ____ Time: _____ Dose: _____ Device Tx #: ____ Time: _____ Therapy Tx #: ____ Time: _____	☐ Aura Other:	Pain (0-10): _____ Start time: _____ End time: _____ Notes:	Sensitive to: ☐ Light ☐ Sound ☐ Nausea ☐ Vomiting ☐ Worse with activity	Stress (0-10): _____ Headache interference (0-10): _____ Hours slept: _____ Sleep quality: ____________ ☐ Physically active ☐ Skipped meal ☐ Hydration ☐ Caffeine	
	☐ Medication ☐ Device ☐ Behaviors & Self-Management Notes:	Medication Tx #: ____ Time: _____ Dose: _____ Device Tx #: ____ Time: _____ Therapy Tx #: ____ Time: _____	☐ Aura Other:	Pain (0-10): _____ Start time: _____ End time: _____ Notes:	Sensitive to: ☐ Light ☐ Sound ☐ Nausea ☐ Vomiting ☐ Worse with activity	Stress (0-10): _____ Headache interference (0-10): _____ Hours slept: _____ Sleep quality: ____________ ☐ Physically active ☐ Skipped meal ☐ Hydration ☐ Caffeine	
	☐ Medication ☐ Device ☐ Behaviors & Self-Management Notes:	Medication Tx #: ____ Time: _____ Dose: _____ Device Tx #: ____ Time: _____ Therapy Tx #: ____ Time: _____	☐ Aura Other:	Pain (0-10): _____ Start time: _____ End time: _____ Notes:	Sensitive to: ☐ Light ☐ Sound ☐ Nausea ☐ Vomiting ☐ Worse with activity	Stress (0-10): _____ Headache interference (0-10): _____ Hours slept: _____ Sleep quality: ____________ ☐ Physically active ☐ Skipped meal ☐ Hydration ☐ Caffeine	
	☐ Medication ☐ Device ☐ Behaviors & Self-Management Notes:	Medication Tx #: ____ Time: _____ Dose: _____ Device Tx #: ____ Time: _____ Therapy Tx #: ____ Time: _____	☐ Aura Other:	Pain (0-10): _____ Start time: _____ End time: _____ Notes:	Sensitive to: ☐ Light ☐ Sound ☐ Nausea ☐ Vomiting ☐ Worse with activity	Stress (0-10): _____ Headache interference (0-10): _____ Hours slept: _____ Sleep quality: ____________ ☐ Physically active ☐ Skipped meal ☐ Hydration ☐ Caffeine	
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2023 VA/DOD Clinical Practice Guideline for Primary Care Management of Headache: www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/VADOD-CPGs or www.healthquality.va.gov/guidelines/pain/headache