HEADACHE DIARY

Patient Name: _____ DOB: _____

1) Please fill in the blank Headache calendar below with the month and dates.
2) Record your headaches on the calendar as they occur using "X" to represent severe headaches and "O" to represent any other headaches.
3) When you use medication to treat a headache, use the Treatment Log to track the effects of treatment.
4) Fax to Cartersville Family Medicine at 770-386-0212 or bring to your next appointment.

Headache Calendar

X = Severe Headache O = Other Headache

Month: _____ Year: _____

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Treatment Log

Goals of Treatment **1)** _____ **2)** _____

Date	Medication Taken	Time Taken	Time You Had Pain Relief	Time You Were Pain Free	Did you achieve your treatment goals?	Side Effects?	Observations (About the headache or treatment)