NEUROLOGIC ASSOCIATES
SPINE, NERVE & BRAIN CENTER
The trusted authorities for exceptional care

Name _____**Month/Date**_____

DETAILED MIGRAINE DIARY

Use this diary to track details of your headaches.

You can share this information with your doctor when talking about your condition and treatment plan.

Instructions

Part 1: Headache severity
Record the strength of your headache pain using an 11-point scale, where 0 = *no pain* and 10 = *the worst pain you have experienced.* Provide scores for different times of the day—morning, afternoon, and evening—to see how your headache pain changes.

Part 2: Headache duration
Record how long your headaches last: less than 4 hours, 4 to 12 hours, or 13 to 24 hours.

Part 3: Headache symptoms
Record all symptoms that accompany each headache. Choose from the list provided, or list any other symptoms in the space(s) noted "Other."

Part 4: Medication use
Record the name and dose of medication used, if any. This includes all acute and preventive medications, both over-the-counter and prescription.

My medications:

MEDICATION NAME	DOSES /FREQUENCY

NEUROLOGIC ASSOCIATES
SPINE, NERVE & BRAIN CENTER
The trusted authorities for exceptional care

DETAILED MIGRAINE DIARY

PART 1: Headache severity (**0**= no pain; **10** worst pain ever experienced)

Day	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																															

PART 2: Headache duration (mark with an **"X"** how long each headache lasted)

Day	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
0 TO 4 hrs.																															
4 TO 12 hrs.																															
13 TO 24 hrs.																															

PART 3: Headache symptoms (mark with an "X" any signs or symptoms experienced with each headache

Day	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
AURA																															
NAUSEA																															
SENTIVITY TO LIGHT																															
SENSITIVITY TO SOUND																															
INABILITY TO WORK																															
INABILITY TO FUNTION																															
THROBBING																															
OTHER																															
OTHER																															

Part 4: Medication use (record the name and dose of medication used, if any)

Day	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
MEDICATION Name:																															
DOSAGE PER DAY																															
MEDICATION Name:																															
DOSAGE PER DAY																															

Adapted from the American Headache Society