The Headache Series

by Dr. Martha Rich

DAILY HEADACHE DIARY

Date:_____ Did you have a headache today? YES NO

If you did have a headache today, please answer the following questions:

Did you wake up with the headache? YES NO

If not, what time did it begin?_____ How long did it last?_____

What did you do to alleviate the pain? *(medication, self-massage, drink water, rest, etc.)*

Did any of your pain alleviations work? Which ones? How long did it take for them to ease your pain?

FOOD AND BEVERAGE DIARY

(Please list everything that you had to eat and drink today other than water. Please approximate what time you ate, and notate if you added any real or artifical sweeteners to your food or beverages)

BREAKFAST	LUNCH	DINNER
Time:	Time:	Time:
MORNING SNACK	**AFTERNOON SNACK**	**EVENING SNACK**
Time:	Time:	Time:

Did you drink water today? YES NO If yes, how much?_____

PHYSICAL SYMPTOMS AND ACTIVITY

Did you exercise today? YES NO If yes, what type and how long?

How many hours did you sit or stand in the same position today?_____

Did you take breaks during that time? YES NO If yes, how many?_____

Were you aware of clenching or grinding your teeth today or last night? YES NO

If yes, what were you doing at that moment?

Did your jaw, neck, shoulders, back, or ears ache at all today? YES NO

If yes, when did you notice the pain and what did you relate it to?

How many hours did you sleep last night? _____ From _____ am / pm to _____ am / pm

Did you feel well-rested when you woke up? YES NO

How many times did you wake up in the night and why (be specific)?

STRESS AND ANXIETY

Rate your stress level for the day on a scale of 1 to 10: _____

What external stress events occurred today? *(work meeting, fight with friend or spouse, bad traffic, tight deadline, etc.)*

What internal stress did you experience today? *(worry about a future or past event, general anxiety, etc.)*

MEDICATIONS, ALCOHOL, CIGARETTES, ETC.

Please list all the medications and substances you used today, including dosages and time of use. Remember, this diary is for your discovery. Be honest with yourself about how much of these substances you may be consuming and open to how some of them may be potentially contributing to your head pain.

MEDICATIONS *Prescription and Over-the-Counter*	**SUPPLEMENTS** *Vitamins, Herbal Supplements, etc.*	**OTHER SUBSTANCES** *Alcohol, Cigarettes, Recreational Drugs, etc.*

Overall, was this a typical day for you? Yes No

If not, what was unusual about your day? *(Was it more relaxed or more stressful than usual?)*

FOR WOMEN ONLY

Are you menstruating today? Yes No

If you track your cycle, what day is it? _____ What is your average cycle length?_____