

MIGRAINE INTENSITY LOG

Month: _____ Name: _____

0
No Pain
1-3
Mild / Distracting
4-6
Moderate / Interference
7-8
Severe / Debilitating
9-10
Emergency / Unbearable

DATE	INTENSITY (0-10)	DURATION	TRIGGERS / SYMPTOMS	MEDICATION / RELIEF
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Additional Observations (Sleep, Weather, Diet):