HEADACHE TRACKER

Month/Year: ____________________

DAY	TIME / DURATION	INTENSITY (1-10)	LOCATION (FRONT, BACK, L/R)	TRIGGERS (FOOD, STRESS, SLEEP)	RELIEF METHOD / MEDS	NOTES
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						

DAY	TIME / DURATION	INTENSITY (1-10)	LOCATION (FRONT, BACK, L/R)	TRIGGERS (FOOD, STRESS, SLEEP)	RELIEF METHOD / MEDS	NOTES
12						
13						
14						
15						

* Intensity Scale: 1 (Mild/Noticeable) to 10 (Debilitating/Emergency)