NAME____________________________
MONTH___________________________
YEAR____________________________

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PATIENT HEADACHE CALANDER

Date	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/Night																															

Scale of 0 - 10 No pain = 0 10 = Pain as bad as it can be

TREATMENT OF MIGRAINE SYMPTOMS (Tablets/Injections/Nasal Sprays/Suppositories/Massage/ice/relaxation etc.)

MED NAME: DOSE:																															
OVERALL RELIEF																															
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Relief: 0 - 1 - 2 - 3 0 = None 1 = Slight Relief 2 = Moderate Relief 3 = Complete Relief

PREVENTATIVE MEDICATIONS

Name: Dose:																															
Name: Dose:																															
Name: Dose:																															

TRIGGERS

MENSTRUAL PERIODS																															
OTHER TRIGGERS																															
1.																															
2.																															
3.																															
4.																															
DISABILITY FOR THE DAY																															

0 = NONE 1 = ABLE TO CARRY OUT ACTIVITIES FAIRLY WELL 2 = DIFFICULTY WITH USUAL ACTIVITY, MAY CANCEL LESS IMPORTANT ONES
3 = HAVE TO MISS WORK (AT LEAST HALF OF THE DAY) OR GO TO BED FOR PART OF THE DAY

PLEASE INDICATE THE OVERALL SEVERITY OF YOUR HEADACHE PROBLEM OVER THE PAST MONTH (CIRCLE ONE):
ABLE TO "TREAT TO GONE WITH MEDS" 0 1 2 3 4 5 6 7 8 9 10 Very Bad (OUT OF CONTOL)