UHN Neuroscience Centre

KNC Headache Clinic
Pre-Consultation Diary

**IMPORTANT: Headache means any pain involving any part of head &/or face

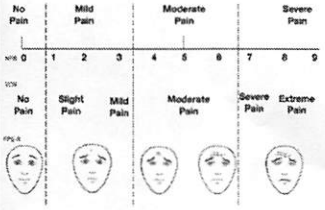
Month / Year: _____

_____**'s Headache Diary**

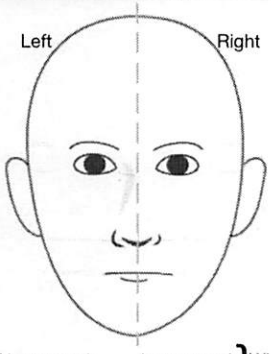
	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Left, Right, Both?							
Severity out of 10							
Duration							
Pain meds used							
Left, Right, Both?							
Severity out of 10							
Duration							
Pain meds used							
Left, Right, Both?							
Severity out of 10							
Duration							
Pain meds used							
Left, Right, Both?							
Severity out of 10							
Duration							
Pain meds used							
Left, Right, Both?							
Severity out of 10							
Duration							
Pain meds used							

} Fill the date in the shaded box

***Menstruating female**
Please circle the date in shaded box if you had your period that day!



Please Indicate where pain occurs



__Upper teeth __Lower teeth } Whic
__Back of head __Neck } side

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SCOPE

Identify your triggers:
1) ↑/↓Sleep, 2) Skipping meals, 3) Alcohol, 4) Bright light, 5) Noise
6) Smells/perfumes, 7) Stress, 8) Dehydration, 9) Weather
10) Caffeine, 11) Exercise/Activity, 12) Positions?, 13) Others?

Do your headaches have nausea or vomiting? _____

Think of all the medications you've tried. Include doses.