Your Headache 0 3 5 8 10

0 = no headache 3 = mild headache 5 = moderate headache
8 = severe headache 10 = extreme headache

NEW ORLEANS HEADACHE & NEUROLOGY CLINIC, A.P.M.C.

Name_____

Date:___/___/____to___/___/___

HEADACHE RECORD

Providing Professional Neurological Care Since 1985

Sunday___	Monday___	Tuesday___	Wednesday__	Thursday___	Friday____	Saturday___	# H. A./wk
Sunday___	Monday___	Tuesday___	Wednesday__	Thursday___	Friday____	Saturday___	
Sunday___	Monday___	Tuesday___	Wednesday__	Thursday___	Friday____	Saturday__	
Sunday___	Monday___	Tuesday___	Wednesday__	Thursday___	Friday____	Saturday__	
Sunday___	Monday___	Tuesday___	Wednesday___	Thursday___	Friday____	Saturday__	
# H.A.							# H.A./month____

Name of med.: A. B. C. D. E. F.

Total for month: # # # # # #

Write for each day: Time headache starts and ends; Headache intensity (0-10); any triggers, medication taken for headache; any other comments. Bring this calendar to your next appointment.