Migraine Assessment

Date				
Time Headache Began				
Time headache Ended				
Warning Signs (aura)				
Location of Pain				
Type of Pain (pressing, throbbing, piercing, etc.)				
Intensity of Pain* (circle one number to the right)	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10
Other Symptoms (nausea, vomiting)				
Medication Taken/ Other Treatment				
Effect of Treatment				
How Headache Affected My Normal Routine				
Hours of Sleep the Night Before the Headache				
What I Ate Before the Headache (caffeine, diet soda, chocolate, hot dogs, food with artificial sweeteners, processed foods)				
Activities Before Headache Occurred				
Important or Stressful Events That Occurred Today				
Comments				