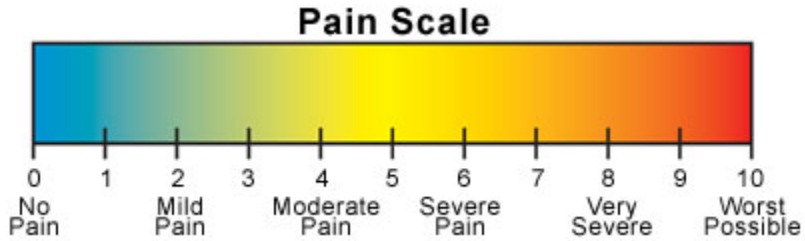
Headache Journal

Name: _____

This journal includes one chart for each month. Please make a notation every day. If your child has no headache, simply put a zero (0) on the appropriate date. On days your child has a headache please write down: how severe the pain is, if you notice any triggers, how long the headache lasts, any associated symptoms, and any medications your child took for the headache.

Coding Information:

Severity Scale: Please ask your child to rate his/her pain on a scale from 0 to 10, with 0 being no pain and 10 being the worst.



Associated Symptoms:

- Nausea and/or Vomiting
- Light Sensitivity (Lights hurt or make the headache worse)
- Noise Sensitivity (Noises make the headache worse)
- Visual disturbance (child see spots or things look “weird”)
- Dizziness

Headache Journal

Month _____

Date	Severity	Triggers	Duration (hours)	Associated Symptoms	Medications Given	Pain after Medication (better, worse, same)
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						