



Headache Tracker

Date	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
Time of pain	AM PM	AM PM	AM PM	AM PM	AM PM
Duration of pain					

Symptoms

Location of pain					
Pain severity Scale of 1 to 10 1=mild 10=severe					
Nausea					
Vomiting					
Sensitivity to light, Sound or smell					
Loss of appetite					
Visual problems					

Other:

Environmental & Physiological Triggers

Stress					
Emotional factors					
Change in sleep patterns					
Hormonal factors Menopause / pregnancy					
Day of menstrual cycle					
Bright lights					
Intense smells					
Loud noises					



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Date	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
Time of pain	AM PM	AM PM	AM PM	AM PM	AM PM
Missed meal					
Change in routine / exercise					
Weather change					
Other birth control / HRT pills					
Food Triggers					
Dairy - cheese / yogurt					
Alcohol					
Chocolate - dark / milk / white					
Food containing MSG					
Citrus					
Caffeine					
Processed meats					
Caffeine					
Nuts					
Type of treatment used & dose taken					
Medication name					
Other e.g.					
<ul style="list-style-type: none"> • Eye patch • Natural therapy • meditation 					

Additional notes: