Compass Health Clinic

How to Use the Compass Health Clinic Headache Diary

Purpose:

The purpose of this headache diary is to help you and your healthcare provider at Compass Health Clinic better understand your headaches. By tracking details about your headaches every day, patterns may emerge that could help identify triggers, effective treatments, or underlying conditions.

Instructions:

1. Consistency is Key: Fill out the diary every day, even if you did not experience a headache. This information is important for identifying patterns.

2. Be Detailed: Provide as much detail as possible for each section. The more information, the better your healthcare provider can tailor your treatment plan.

3. Bring it to Appointments: Bring this diary to every appointment at Compass Health Clinic. It will serve as a valuable tool in your treatment process.

Why It's Important:

Filling out the diary daily helps in:

- Identifying headache triggers such as certain foods, stress, or sleep patterns.
- Monitoring the effectiveness of prescribed medications or treatments.
- Providing your healthcare provider with detailed insights to better customize your care plan.
- Understanding the impact of lifestyle factors on your headaches.

Compass Health Clinic Daily Headache Diary

1. Headache Location

Where did you feel the headache? (e.g., forehead, temples, back of the head, one side, etc.)

Location: _____

2. Headache Severity

On a scale of 0-10, how severe was your headache?

Severity: _____ / 10

3. Headache Frequency

How often did you experience the headache today?

Frequency:

- Once
- Multiple times (Please specify: _____)
- Continuous

4. Associated Symptoms

Did you experience any of the following symptoms with your headache? (Check all that apply)

- Nausea
- Vomiting
- Sensitivity to light (Photophobia)
- Sensitivity to sound (Phonophobia)
- Dizziness
- Visual disturbances
- Others (Please specify: _____)

5. Medication Used

What medication did you take for your headache?

Medication Name: _____

Dosage: _____

Effectiveness:

- None

- Mild relief

- Moderate relief

- Complete relief

6. Hours of Sleep

How many hours did you sleep last night?

Hours of Sleep: _____ hours

7. Daily Activities

Did you engage in any of the following activities today? (Check all that apply)

- Work/School

- Physical exercise

- Social activities

- Screen time (TV/Computer/Phone)

- Stressful events (Please specify: _____)

- Others (Please specify: _____)

8. Prodrome Symptoms

Did you experience any prodromes (early symptoms) before your headache began? Prodromes can include mood changes, fatigue, food cravings, neck stiffness, or increased sensitivity to light and sound.

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What medication did you take for your headache?

Medication Name: _____

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Effectiveness:

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Where did you feel the headache? (e.g., forehead, temples, back of the head, one side, etc.)

Location: _____

2. Headache Severity

On a scale of 0-10, how severe was your headache?

Severity: _____ / 10

3. Headache Frequency

How often did you experience the headache today?

Frequency:

- Once
- Multiple times (Please specify: _____)
- Continuous

4. Associated Symptoms

Did you experience any of the following symptoms with your headache? (Check all that apply)

- Nausea
- Vomiting
- Sensitivity to light (Photophobia)
- Sensitivity to sound (Phonophobia)
- Dizziness
- Visual disturbances
- Others (Please specify: _____)

5. Medication Used

What medication did you take for your headache?

Medication Name: _____

Dosage: _____

Effectiveness:

- None

- Mild relief

- Moderate relief

- Complete relief

6. Hours of Sleep

How many hours did you sleep last night?

Hours of Sleep: _____ hours

7. Daily Activities

Did you engage in any of the following activities today? (Check all that apply)

- Work/School

- Physical exercise

- Social activities

- Screen time (TV/Computer/Phone)

- Stressful events (Please specify: _____)

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8. Prodrome Symptoms

Did you experience any prodromes (early symptoms) before your headache began? Prodromes can include mood changes, fatigue, food cravings, neck stiffness, or increased sensitivity to light and sound.

Prodrome Symptoms: _____

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