7-Day Diary

Patient Name _____ Dates: _____

Floating Hospital for Children at Tufts Medical Center

During one full week, please record your child's headache **intensity on a scale from 0 (no pain) to 10 (severe pain), duration of pain, location of pain,** and any relevant additional information such as **nausea/vision changes, activity prior to headache, and what helped alleviate the pain?**

DAY	Breakfast	Mid-Morning	Lunch	Mid-Afternoon	Dinner	Exercise
MONDAY						
TUESDAY						
WEDNESDAY						
THURSDAY						
FRIDAY						
SATURDAY						
SUNDAY						

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Patient Name _____

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DAY	Breakfast	Mid-Morning	Lunch	Mid-Afternoon	Dinner	Exercise
MONDAY _____ START DATE						
TUESDAY						
WEDNESDAY						
THURSDAY						
FRIDAY						
SATURDAY						
SUNDAY						