GET WHAT YOU NEED OUT OF LIFE℠

My Personal Headache Diary

USE THIS DIARY AND SHARE WITH YOUR HEALTHCARE PROVIDER AT YOUR NEXT VISIT.
FOR ADDITIONAL COPIES, VISIT WWW.SPIRITOFWOMEN.COM/GETWHATYOUNEEDOUTOFLIFE.

Date/Time (when your headache began):

Day of the Week	Activity (prior to or at start of headache):	Severity (write in number)	Disability (write in number)
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Sunday			

Severity (how severe the headache is at its worst):
? 1 - Mild 2 3 4 5 – The worst headache you've ever had

How disabling is the headache?
? 1 – Mild and not interfering with what you normally do
? 5 – Severe and keeps you from doing work or daily activities

Medications Taken for Relief — include the time, dose, and outcome

Medication Name	Time	Dose	Outcome

Time (when your headache **stopped**):_____

Spirit of Women

Get What You Need Out of Life℠ is brought to you by your local Spirit of Women® hospital. Spirit of Women is a coalition of hospitals and healthcare providers across the United States that ascribe to the highest standards of excellence in women's health, education, and community outreach.

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