Associates in Neuroscience

ASSOCIATES IN PEDIATRIC NEUROLOGY, SC

Daily Headache Log

Name:_____ Date of Birth: _____/_____/_____ **Priti Singh, MD**

Week Of _____	**SUNDAY**	**MONDAY**	**TUESDAY**	**WEDNESDAY**	**THURSDAY**	**FRIDAY**	**SATURDAY**
	Date	Date	Date	Date	Date	Date	Date
What time did your Headache Start?							
Describe symptoms (Pounding, stabbing, etc)							
Where is the headache located (Front, Back, etc)?							
How long did the headache last?							
Rate your headache on a scale of 1-10							
What actions were taken to help with headache pain (sleep, medication, dark room, etc)?							
How many hours of sleep did you get last night?							
What activities were you doing when the headache started?							
Have you experienced any stress?							
What did you eat today?							
For females, please put an X on the days in which you have your period.							

Please keep an accurate log of your headaches. This will help with the treatment and diagnosis of your symptoms.
If you have any questions or concerns please do not hesitate to contact our office at (630) 230-3372
Please utilize the back of this sheet for additional notes