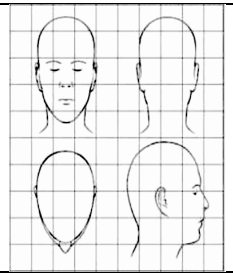
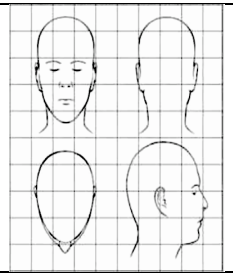
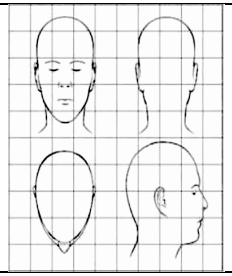
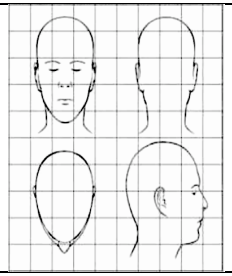
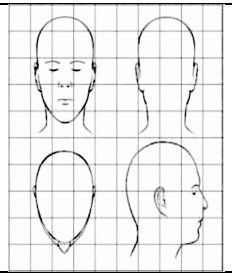
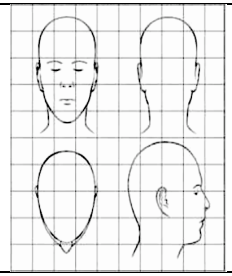
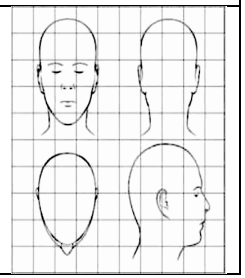
TCC 7 Day Headache Diary (D/M/Y): _____ Name: _____

	Day						
	1	2	3	4	5	6	7
Headache time of onset							
Possible causes/triggers (stress, fatigue, hunger, electronic devices, menstruation, sleep issues)							
Symptoms prior to the headache (nothing, vision changes, flashing lights, nausea, dizziness, other)							
Intensity of pain (0 - 10)							
How did the headache feel? (dull ache, sharp, numb, pressure, throbbing, pins & needles, other)							
Location (mark **X**'s on diagram)							

(continued…)	Day						
	1	2	3	4	5	6	7
Associated symptoms (none, nausea, eye tearing, stuffy nose, vision changes, confusion, other)							
Things that worsened the headache (nothing, specific activity, lights, sound, other)							
Things that made the headache better (nothing, medication, lying down, dark room, drinking water, relaxation techniques, other)							
How long did it last? (minutes, hours, or days)							
Did any symptoms linger after the headache? (nothing, nausea, weakness, fatigue, other)							