



1-800-758-8746 | [www.MigreLief.com](http://www.MigreLief.com)

# Migraine Diary

Track and manage your migraines before they manage you!

*A migraine diary is a tool for managing your migraines by tracking your symptoms and recording important facts about your migraines – before, during, and after they occur. The diary can help you identify potential triggers and monitor the effectiveness of treatments and alternative therapies. The data you generate can also help your doctor correctly diagnose migraine or other disorders. Continue to record in the diary for each migraine experienced. Note: If you are starting the "MigreLief Nutritional Regimen for Migraine Sufferers," be sure to note the start date.*

My migraine began:

Date: (mm/dd/yyyy) \_\_\_/\_\_\_/\_\_\_

Time: \_\_\_:\_\_\_  AM  PM

My migraine ended:

Date: (mm/dd/yyyy) \_\_\_/\_\_\_/\_\_\_

Time: \_\_\_:\_\_\_  AM  PM

Symptoms before my headache:

Visual disturbances or aura?  Yes  No

Motor disturbances?  Yes  No

Numbness/tingling?  Yes  No

Other \_\_\_\_\_

My headache symptoms:

Numbness/tingling?  Yes  No

Pain intensity:  1  2  3  4  5  
 (1= less intense 5= more intense)

Description of Pain: \_\_\_\_\_  
 (eg. throbbing, stabbing, pounding, dull ache, pulsating)

Location of pain: (mark with "Xs")



Other Symptoms: \_\_\_\_\_

Eg. nausea, sensitivity to light, vomiting, sensitivity to smells or sound, abdominal pain (especially children), vertigo, dizziness etc.

MY MIGRAINE TREATMENT

Medications I took including dosages:

\_\_\_\_\_

\_\_\_\_\_

Treatment effectiveness  1  2  3  4  5  
 (1= not effective 5= most effective)

Time it took for treatment to work:

\_\_\_\_\_

Nonmedical treatment: \_\_\_\_\_

(e.g. sleep, heat, cold compresses, dark, massage, other)

Rebound headache: (Migraine returned soon after treatment)

How soon?

\_\_\_\_\_

Symptoms:

\_\_\_\_\_

Other: \_\_\_\_\_

Possible Headache Triggers:

- Changes in sleeping pattern.
- Changes in eating pattern.
- Food-Drink
- Environmental (weather, lights, noises, odor)
- Activity or exercise
- Hormonal (menstrual, birth-control, estrogen Supplements)
- Medication
- Emotions (stress, anger, depression, fatigue, anxiety)
- Other \_\_\_\_\_

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- Other \_\_\_\_\_

\_\_\_\_\_

# MIGRAINE HISTORY OVERVIEW

MIGRELIEF START DATE \_\_\_\_\_

	A		B	C	D	E		F	G	H
	Migraine Time	Date	Intensity (1-10)	Duration	Medications	Treatment Other	Treatment Time	Comments & Triggers		
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										
14										
15										
16										
17										
18										
19										

For additional migraine information & helpful hints go to [www.MigreLief.com](http://www.MigreLief.com) and ask our Health Advisor.