AKESO
MIGRELIEF®
Triple Therapy with Puracol™

1-800-758-8746 | 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 for Migraine Sufferers," be sure to note the start date.

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Migraine Diary

migrelief.com 1-800-758-8746

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
1	Migraine Time	Date	Intensity (1-10)	Duration	Treatment Medications	Other	Treatment Time	Comments & Triggers
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 and ask our Health Advisor.