Date:____________________ Entry #______

Start time:		End time:		Duration:	

Migraine

Cluster

Sinus

TMJ

Tension

PAIN LEVEL

1	2	3	4	5	6	7	8	9	10

DETAILED DESCRIPTION

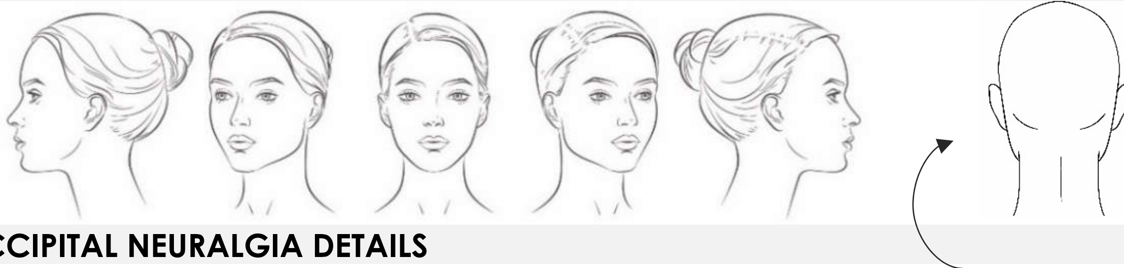
☐ Constant ☐ Squeezing ☐ Throbbing ☐ Pounding
☐ Dull aching ☐ Burning ☐ Sharp ☐ Debilitating

Other: ____

ONSET

☐ Slow ☐ Average ☐ Rapid ☐ Sudden

WHERE DOES IT HURT, EXACTLY?



OCCIPITAL NEURALGIA DETAILS

Woke up on back? ☐ Yes ☐ No
Occipital Neuralgia Pain? ☐ Yes ☐ No
Nerve blocks? ☐ Yes ☐ No
Physical Therapy? ☐ Yes ☐ No

OTHER SYMPTOMS

☐ Lightheaded ☐ Dizziness or Vertigo ☐ Cognitive issues
☐ Light sensitivity ☐ Sound sensitivity ☐ Auras
☐ Muscle stiffness ☐ Smell sensitivity ☐ Muscle aches

Other:____

FEELING SICK?

☐ Nausea ☐ Diarrhea ☐ Vomiting ☐ Sore throat
☐ Congestion ☐ Coughing ☐ Chills ☐ Fever

Mood	Mental Clarity	Energy Levels
①②③④⑤	①②③④⑤	①②③④⑤

Other symptoms / notes

SLEEP

Hours ________

Quality ① ② ③ ④ ⑤

STRESS LEVEL

None	Low	Medium	High	Max

WEATHER

☐ Hot ☐ Mild ☐ Cold ☐ Dry ☐ Humid ☐ Wet

BM Pressure:

Allergen Levels:

Air Quality:

Wind:

FOOD / SUPPLEMENTS / DRINKS

item/meal	*time*	*meds/supplements*	*dose*	*time*
		☐ Daily medication taken		

Water	*Caffeine*	*Alcohol*

x ______

x ______

FATIGUE LEVELS

1	2	3	4	5	6	7	8	9	10

SCREEN TIME / READING

☐ None ☐ Some ☐ A lot Total time: ____________________

☐ Sitting ☐ Standing ☐ Mixture Breaks every: ____________________

PHYSICAL ACTIVITY

☐ None ☐ A bit ☐ Some ☐ A lot ☐ I'm beat

EXERCISE DETAILS

RELIEF MEASURES

☐ Medication ☐ Massage ☐ Sleep ☐ Exercise

☐ Water ☐ Cold/Ice ☐ Heat/Bath ☐ Other

Other: ____

Did it work? ☐ No ☐ A bit ☐ 50% ☐ Mostly ☐ 100%

Notes