MIGRAINE LOG

NAME:					STARTING LOCATION - (select ONE and indicate R or L)					What seemed to "bring on" the migraine? (Check all that apply)												
Date	Start Time	End Time	Intensity (1-10)	Medications Taken	Behind Eye	Temple	Forehead	Back of Head/Neck	Other (specify in notes)	Stress	Bright Light	Change in Weather	Loud Noise	Heavy Lifting	Airplane Travel	Fatigue	Hunger/Missed Meals	Sexual Activity	Straining/Bending	Specific Foods	Other (specify in notes)	NOTES - please list anything else you feel is different or important about this headache