Headache Clinic,
Paediatric Neurosciences Unit
Royal Hospital for Children
Glasgow, G51 4TF

Headache diary

Name: Date of birth: Sex:

Address:

Attack number	1	2	3	4	5	6
Date						
Time started						
Time resolved						
Severity of headache*						
Type of headache**						
What may have started it off?						
Any warnings before start of headache						
Any loss of appetite?						
Nausea?						
Vomiting?						
Does light make it worse?						
Does noise make it worse?						
Is it worse by walking?						
Does rest make it better?						
Does sleep make it better?						
Is it better after paracetamol?						

*Severity: Write 1 if headache is not interfering with normal activities
Write 2 if headache is interfering with some activities
Write 3 if headache is interfering with all activities

**Type of pain: Choose one of the following or your own descriptions: Throbbing, hitting, banging, Tightness, pressure, squeezing, Sharp, stabbing, Dull or can't describe

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