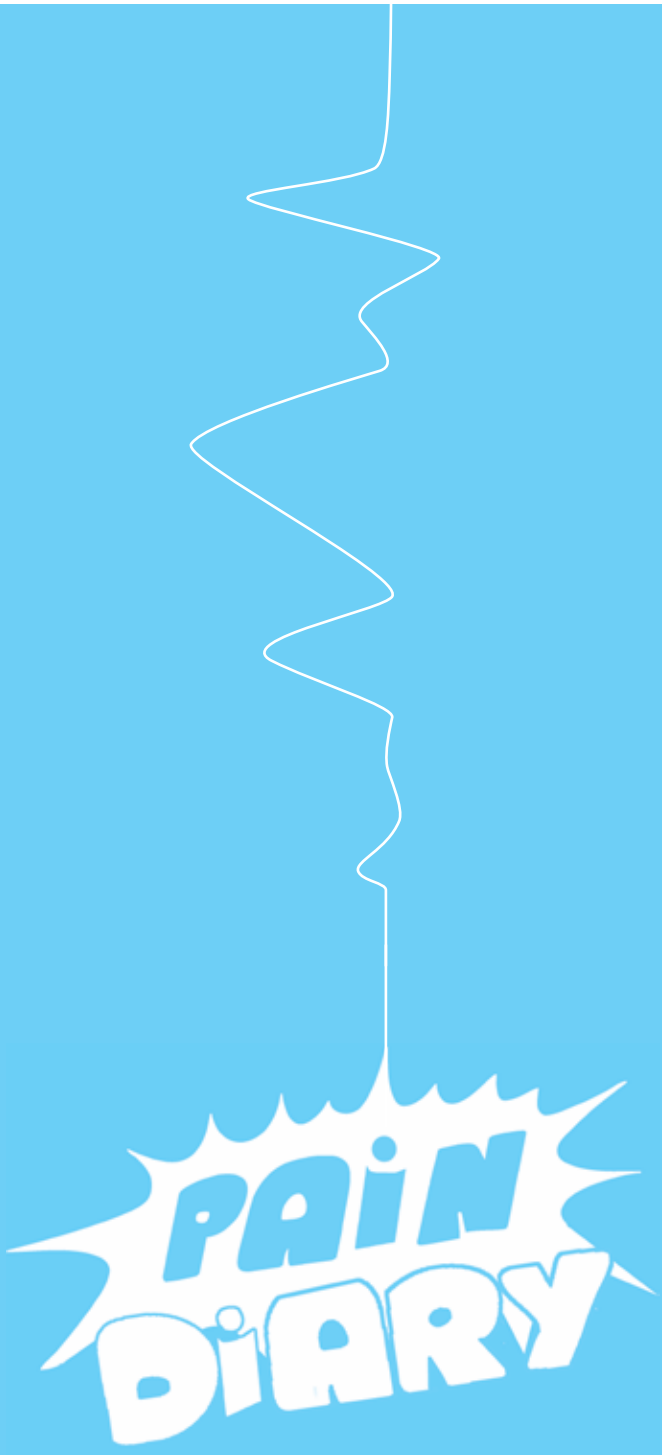

HEADACHE DIARY FOR CHILDREN AND ADOLESCENTS

German Paediatric Pain Centre
Children's and Adolescents' Hospital, Datteln
Department of Children's Pain Therapy and
Paediatric Palliative Care
Witten/Herdecke University, Faculty of Health, School of Medicine

Phone +49-2363-975-187
Fax: +49-2363-975-181

E-Mail: info@deutsches-kinderschmerzzentrum.de
Web: www.german-paediatric-pain-centre.org
www.facebook.com/DeutschesKinderschmerzzentrum

Headache Diary

Design: Dirk Pleyer, 1:BEIDE, Bochum,
Barbara Gertz, German Paediatric Pain Centre
Layout: Barbara Gertz

German
Paediatric Pain Centre

Vestische Kinder- und
Jugendklinik Datteln
Universität Witten/Herdecke

Hello!

Filling out this headache diary is a very important step to improve your headache condition.
The diary helps you to distinguish between different types of headache. We will first ask you how strong the pain is: „0“ means that you have no pain. „10“ means that you have the strongest pain. You will also be asked about other symptoms occurring during headache (e.g. nausea) or if your headache gets worse when you move.
It is very important to find out what is best to ease your headache. The diary encourages you to write down all your observations, e.g. how you treated your headache and how effective it was.

Clearly, this diary aims at your observation. This also means there are no right or wrong answers. The only thing that matters is what you think and feel about your pain.
Therefore, you (and no other person) should fill out the diary. Younger children who are not able to fill out the diary without the help of their parents are an exception. In this case, we would ask the parents to help.
It is important to fill out the diary every day until you have the next appointment with us. With your daily reports we can hopefully find a way to relieve your headaches. So, please bring the diary to the next appointment!

And for now, let's get started! Good luck!

Your Pain Team

1. YOUR NAME:

2. YOUR AGE:

Week from..... up to	MONDAY	TUESDAY	WEDNESDAY
Did something special happen today? If yes, was it good ☺ or bad ☹?	☐ Yes ☐ No ☐ ☺ ☐ ☹	☐ Yes ☐ No ☐ ☺ ☐ ☹	☐ Yes ☐ No ☐ ☺ ☐ ☹
Describe briefly what happened.			
Did you have a headache today? If "yes" please complete the following items. If "no" you can stop here.	☐ Yes ☐ No (stop here)	☐ Yes ☐ No (stop here)	☐ Yes ☐ No (stop here)
How strong has your headache been?	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
When did your headache occur? Mark all hours in which you had headache (each box stands for an hour) with an "x". Please also mark the box when you took medication with a "o".	0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 17 19 20 21 22 23	0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 17 19 20 21 22 23	0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 17 19 20 21 22 23
Did your headache get worse during exercises (e.g. climbing stairs, running, bouncing)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Did any other symptoms occur?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Did you feel nauseated?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Did you vomit?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Have you been sensitive to light?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Have you been sensitive to noise?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Have you been dizzy?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Did you have impaired vision?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Any other symptoms?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If so, which ones?			
Did you take medication because of your headache?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If so, which one?			
How effective was it? Please rate on a scale from 0–10 (0= not at all; 10= very effective).	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
Did you do something while you had headache (e.g. distraction, play, rest)?			
How effective was it? Please rate on a scale from 0–10 (0= not at all; 10= very effective).	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
Did your headache keep you from school?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Or did your headache keep you from anything else (e.g. homework, sport, meeting friends)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If so, from what?			
Was your headache somewhat special today?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If so, what was special?			
You may also paint, write, stamp or stick anything you like in this box.			

THURSDAY	FRIDAY	SATURDAY	SUNDAY
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ ☺ ☐ ☹	☐ ☺ ☐ ☹	☐ ☺ ☐ ☹	☐ ☺ ☐ ☹
☐ Yes	☐ Yes	☐ Yes	☐ Yes
☐ No (stop here)	☐ No (stop here)	☐ No (stop here)	☐ No (stop here)
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7
8 9 10 11 12 13 14 15	8 9 10 11 12 13 14 15	8 9 10 11 12 13 14 15	8 9 10 11 12 13 14 15
16 17 17 19 20 21 22 23	16 17 17 19 20 21 22 23	16 17 17 19 20 21 22 23	16 17 17 19 20 21 22 23
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
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☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Week from..... up to	MONDAY	TUESDAY	WEDNESDAY
Did something special happen today? If yes, was it good ☺ or bad ☹?	☐ Yes ☐ No ☐ ☺ ☐ ☹	☐ Yes ☐ No ☐ ☺ ☐ ☹	☐ Yes ☐ No ☐ ☺ ☐ ☹
Describe briefly what happened.			
Did you have a headache today? If "yes" please complete the following items. If "no" you can stop here.	☐ Yes ☐ No (stop here)	☐ Yes ☐ No (stop here)	☐ Yes ☐ No (stop here)
How strong has your headache been?	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
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Did your headache get worse during exercises (e.g. climbing stairs, running, bouncing)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Did any other symptoms occur?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Did you feel nauseated?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Did you vomit?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Have you been sensitive to light?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Have you been sensitive to noise?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Have you been dizzy?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Did you have impaired vision?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Any other symptoms?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If so, which ones?			
Did you take medication because of your headache?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If so, which one?			
How effective was it? Please rate on a scale from 0–10 (0= not at all; 10= very effective).	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
Did you do something while you had headache (e.g. distraction, play, rest)?			
How effective was it? Please rate on a scale from 0–10 (0= not at all; 10= very effective).	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
Did your headache keep you from school?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Or did your headache keep you from anything else (e.g. homework, sport, meeting friends)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If so, from what?			
Was your headache somewhat special today?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If so, what was special?			
You may also paint, write, stamp or stick anything you like in this box.			

THURSDAY	FRIDAY	SATURDAY	SUNDAY
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ ☺ ☐ ☹	☐ ☺ ☐ ☹	☐ ☺ ☐ ☹	☐ ☺ ☐ ☹
☐ Yes	☐ Yes	☐ Yes	☐ Yes
☐ No (stop here)	☐ No (stop here)	☐ No (stop here)	☐ No (stop here)
0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7
8 9 10 11 12 13 14 15	8 9 10 11 12 13 14 15	8 9 10 11 12 13 14 15	8 9 10 11 12 13 14 15
16 17 17 19 20 21 22 23	16 17 17 19 20 21 22 23	16 17 17 19 20 21 22 23	16 17 17 19 20 21 22 23
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Week from.................. up to	MONDAY	TUESDAY	WEDNESDAY
Did something special happen today? If yes, was it good ☺ or bad ☹?	☐ Yes ☐ No ☐ ☺ ☐ ☹	☐ Yes ☐ No ☐ ☺ ☐ ☹	☐ Yes ☐ No ☐ ☺ ☐ ☹
Describe briefly what happened.	________	________	________
Did you have a headache today? If "yes" please complete the following items. If "no" you can stop here.	☐ Yes ☐ No (stop here)	☐ Yes ☐ No (stop here)	☐ Yes ☐ No (stop here)
How strong has your headache been?	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ 0 1 2 3 4 5 6 7 8 9 10	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ 0 1 2 3 4 5 6 7 8 9 10	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ 0 1 2 3 4 5 6 7 8 9 10
When did your headache occur? Mark all hours in which you had headache (each box stands for an hour) with an "x". Please also mark the box when you took medication with a "o".	0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 17 19 20 21 22 23	0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 17 19 20 21 22 23	0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 17 19 20 21 22 23
Did your headache get worse during exercises (e.g. climbing stairs, running, bouncing)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Did any other symptoms occur?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Did you feel nauseated?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Did you vomit?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Have you been sensitive to light?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Have you been sensitive to noise?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Have you been dizzy?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Did you have impaired vision?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Any other symptoms?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If so, which ones?	________	________	________
Did you take medication because of your headache? If so, which one?	☐ Yes ☐ No ________	☐ Yes ☐ No ________	☐ Yes ☐ No ________
How effective was it? Please rate on a scale from 0–10 (0= not at all; 10= very effective).	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ 0 1 2 3 4 5 6 7 8 9 10	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ 0 1 2 3 4 5 6 7 8 9 10	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ 0 1 2 3 4 5 6 7 8 9 10
Did you do something while you had headache (e.g. distraction, play, rest)?	________ ________ ________	________ ________ ________	________ ________ ________
How effective was it? Please rate on a scale from 0–10 (0= not at all; 10= very effective).	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ 0 1 2 3 4 5 6 7 8 9 10	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ 0 1 2 3 4 5 6 7 8 9 10	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ 0 1 2 3 4 5 6 7 8 9 10
Did your headache keep you from school?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Or did your headache keep you from anything else (e.g. homework, sport, meeting friends)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If so, from what?	________	________	________
Was your headache somewhat special today?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If so, what was special?	________	________	________
You may also paint, write, stamp or stick anything you like in this box.			

THURSDAY	FRIDAY	SATURDAY	SUNDAY
☐ Yes ☐ No ☐ ☺ ☐ ☹	☐ Yes ☐ No ☐ ☺ ☐ ☹	☐ Yes ☐ No ☐ ☺ ☐ ☹	☐ Yes ☐ No ☐ ☺ ☐ ☹
☐ Yes ☐ No (stop here)	☐ Yes ☐ No (stop here)	☐ Yes ☐ No (stop here)	☐ Yes ☐ No (stop here)
☐☐☐☐☐☐☐☐☐☐☐ 0 1 2 3 4 5 6 7 8 9 10	☐☐☐☐☐☐☐☐☐☐☐ 0 1 2 3 4 5 6 7 8 9 10	☐☐☐☐☐☐☐☐☐☐☐ 0 1 2 3 4 5 6 7 8 9 10	☐☐☐☐☐☐☐☐☐☐☐ 0 1 2 3 4 5 6 7 8 9 10
0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 17 19 20 21 22 23	0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 17 19 20 21 22 23	0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 17 19 20 21 22 23	0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 17 19 20 21 22 23
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
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☐☐☐☐☐☐☐☐☐☐☐ 0 1 2 3 4 5 6 7 8 9 10	☐☐☐☐☐☐☐☐☐☐☐ 0 1 2 3 4 5 6 7 8 9 10	☐☐☐☐☐☐☐☐☐☐☐ 0 1 2 3 4 5 6 7 8 9 10	☐☐☐☐☐☐☐☐☐☐☐ 0 1 2 3 4 5 6 7 8 9 10
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Week from................... up to	MONDAY	TUESDAY	WEDNESDAY
Did something special happen today? If yes, was it good ☺ or bad ☹? Describe briefly what happened.	☐ Yes ☐ No ☐ ☺ ☐ ☹ __________	☐ Yes ☐ No ☐ ☺ ☐ ☹ __________	☐ Yes ☐ No ☐ ☺ ☐ ☹ __________
Did you have a headache today? If "yes" please complete the following items. If "no" you can stop here.	☐ Yes ☐ No (stop here)	☐ Yes ☐ No (stop here)	☐ Yes ☐ No (stop here)
How strong has your headache been?	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
When did your headache occur? Mark all hours in which you had headache (each box stands for an hour) with an "x". Please also mark the box when you took medication with a "o".	0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 17 19 20 21 22 23	0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 17 19 20 21 22 23	0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 17 19 20 21 22 23
Did your headache get worse during exercises (e.g. climbing stairs, running, bouncing)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Did any other symptoms occur?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Did you feel nauseated?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Did you vomit?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Have you been sensitive to light?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Have you been sensitive to noise?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Have you been dizzy?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Did you have impaired vision?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Any other symptoms?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If so, which ones?	__________	__________	__________
Did you take medication because of your headache? If so, which one?	☐ Yes ☐ No __________	☐ Yes ☐ No __________	☐ Yes ☐ No __________
How effective was it? Please rate on a scale from 0–10 (0= not at all; 10= very effective).	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
Did you do something while you had headache (e.g. distraction, play, rest)?	__________ __________ __________	__________ __________ __________	__________ __________ __________
How effective was it? Please rate on a scale from 0–10 (0= not at all; 10= very effective).	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
Did your headache keep you from school?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Or did your headache keep you from anything else (e.g. homework, sport, meeting friends)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If so, from what?	__________	__________	__________
Was your headache somewhat special today?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If so, what was special?	__________	__________	__________
You may also paint, write, stamp or stick anything you like in this box.			

THURSDAY	FRIDAY	SATURDAY	SUNDAY
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ ☺ ☐ ☹	☐ ☺ ☐ ☹	☐ ☺ ☐ ☹	☐ ☺ ☐ ☹
☐ Yes	☐ Yes	☐ Yes	☐ Yes
☐ No (stop here)	☐ No (stop here)	☐ No (stop here)	☐ No (stop here)
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7
8 9 10 11 12 13 14 15	8 9 10 11 12 13 14 15	8 9 10 11 12 13 14 15	8 9 10 11 12 13 14 15
16 17 17 19 20 21 22 23	16 17 17 19 20 21 22 23	16 17 17 19 20 21 22 23	16 17 17 19 20 21 22 23
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Week from..... up to	MONDAY	TUESDAY	WEDNESDAY
Did something special happen today? If yes, was it good ☺ or bad ☹?	☐ Yes ☐ No ☐ ☺ ☐ ☹	☐ Yes ☐ No ☐ ☺ ☐ ☹	☐ Yes ☐ No ☐ ☺ ☐ ☹
Describe briefly what happened.			
Did you have a headache today? If "yes" please complete the following items. If "no" you can stop here.	☐ Yes ☐ No (stop here)	☐ Yes ☐ No (stop here)	☐ Yes ☐ No (stop here)
How strong has your headache been?	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
When did your headache occur? Mark all hours in which you had headache (each box stands for an hour) with an "x". Please also mark the box when you took medication with a "o".	0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 17 19 20 21 22 23	0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 17 19 20 21 22 23	0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 17 19 20 21 22 23
Did your headache get worse during exercises (e.g. climbing stairs, running, bouncing)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Did any other symptoms occur?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Did you feel nauseated?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Did you vomit?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Have you been sensitive to light?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Have you been sensitive to noise?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Have you been dizzy?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Did you have impaired vision?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Any other symptoms?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If so, which ones?			
Did you take medication because of your headache?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If so, which one?			
How effective was it? Please rate on a scale from 0–10 (0= not at all; 10= very effective).	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
Did you do something while you had headache (e.g. distraction, play, rest)?			
How effective was it? Please rate on a scale from 0–10 (0= not at all; 10= very effective).	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
Did your headache keep you from school?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Or did your headache keep you from anything else (e.g. homework, sport, meeting friends)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If so, from what?			
Was your headache somewhat special today?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If so, what was special?			
You may also paint, write, stamp or stick anything you like in this box.			

THURSDAY	FRIDAY	SATURDAY	SUNDAY
☐ Yes ☐ No ☐ ☺ ☐ ☹	☐ Yes ☐ No ☐ ☺ ☐ ☹	☐ Yes ☐ No ☐ ☺ ☐ ☹	☐ Yes ☐ No ☐ ☺ ☐ ☹
☐ Yes ☐ No (stop here)	☐ Yes ☐ No (stop here)	☐ Yes ☐ No (stop here)	☐ Yes ☐ No (stop here)
0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 17 19 20 21 22 23	0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 17 19 20 21 22 23	0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 17 19 20 21 22 23	0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 17 19 20 21 22 23
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Week from..... up to	MONDAY	TUESDAY	WEDNESDAY
Did something special happen today? If yes, was it good ☺ or bad ☹?	☐ Yes ☐ No ☐ ☺ ☐ ☹	☐ Yes ☐ No ☐ ☺ ☐ ☹	☐ Yes ☐ No ☐ ☺ ☐ ☹
Describe briefly what happened.			
Did you have a headache today? If "yes" please complete the following items. If "no" you can stop here.	☐ Yes ☐ No (stop here)	☐ Yes ☐ No (stop here)	☐ Yes ☐ No (stop here)
How strong has your headache been?	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
When did your headache occur? Mark all hours in which you had headache (each box stands for an hour) with an "x". Please also mark the box when you took medication with a "o".	0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 17 19 20 21 22 23	0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 17 19 20 21 22 23	0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 17 19 20 21 22 23
Did your headache get worse during exercises (e.g. climbing stairs, running, bouncing)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Did any other symptoms occur?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Did you feel nauseated?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Did you vomit?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Have you been sensitive to light?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Have you been sensitive to noise?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Have you been dizzy?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Did you have impaired vision?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Any other symptoms?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If so, which ones?			
Did you take medication because of your headache?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If so, which one?			
How effective was it? Please rate on a scale from 0–10 (0= not at all; 10= very effective).	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
Did you do something while you had headache (e.g. distraction, play, rest)?			
How effective was it? Please rate on a scale from 0–10 (0= not at all; 10= very effective).	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
Did your headache keep you from school?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Or did your headache keep you from anything else (e.g. homework, sport, meeting friends)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If so, from what?			
Was your headache somewhat special today?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If so, what was special?			
You may also paint, write, stamp or stick anything you like in this box.			

THURSDAY	FRIDAY	SATURDAY	SUNDAY
☐ Yes ☐ No ☐ ☺ ☐ ☹	☐ Yes ☐ No ☐ ☺ ☐ ☹	☐ Yes ☐ No ☐ ☺ ☐ ☹	☐ Yes ☐ No ☐ ☺ ☐ ☹
☐ Yes ☐ No (stop here)	☐ Yes ☐ No (stop here)	☐ Yes ☐ No (stop here)	☐ Yes ☐ No (stop here)
0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 17 19 20 21 22 23	0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 17 19 20 21 22 23	0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 17 19 20 21 22 23	0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 17 19 20 21 22 23
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Week from.................... **up to ....**	**MONDAY**	**TUESDAY**	**WEDNESDAY**
Did something special happen today? If yes, was it good ☺ or bad ☹? Describe briefly what happened.	☐ Yes ☐ No ☐ ☺ ☐ ☹ __________	☐ Yes ☐ No ☐ ☺ ☐ ☹ __________	☐ Yes ☐ No ☐ ☺ ☐ ☹ __________
Did you have a headache today? If "yes" please complete the following items. If "no" you can stop here.	☐ Yes ☐ No (stop here)	☐ Yes ☐ No (stop here)	☐ Yes ☐ No (stop here)
How strong has your headache been?	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ 0 1 2 3 4 5 6 7 8 9 10	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ 0 1 2 3 4 5 6 7 8 9 10	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ 0 1 2 3 4 5 6 7 8 9 10
When did your headache occur? Mark all hours in which you had headache (each box stands for an hour) with an "x". Please also mark the box when you took medication with a "o".	0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 17 19 20 21 22 23	0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 17 19 20 21 22 23	0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 17 19 20 21 22 23
Did your headache get worse during exercises (e.g. climbing stairs, running, bouncing)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Did any other symptoms occur?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Did you feel nauseated?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Did you vomit?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Have you been sensitive to light?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Have you been sensitive to noise?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Have you been dizzy?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Did you have impaired vision?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Any other symptoms?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If so, which ones?	__________	__________	__________
Did you take medication because of your headache? If so, which one?	☐ Yes ☐ No __________	☐ Yes ☐ No __________	☐ Yes ☐ No __________
How effective was it? Please rate on a scale from 0–10 (0= not at all; 10= very effective).	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ 0 1 2 3 4 5 6 7 8 9 10	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ 0 1 2 3 4 5 6 7 8 9 10	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ 0 1 2 3 4 5 6 7 8 9 10
Did you do something while you had headache (e.g. distraction, play, rest)?	__________ __________ __________	__________ __________ __________	__________ __________ __________
How effective was it? Please rate on a scale from 0–10 (0= not at all; 10= very effective).	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ 0 1 2 3 4 5 6 7 8 9 10	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ 0 1 2 3 4 5 6 7 8 9 10	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ 0 1 2 3 4 5 6 7 8 9 10
Did your headache keep you from school?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Or did your headache keep you from anything else (e.g. homework, sport, meeting friends)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If so, from what?	__________	__________	__________
Was your headache somewhat special today?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If so, what was special?	__________	__________	__________
You may also paint, write, stamp or stick anything you like in this box.			

THURSDAY	FRIDAY	SATURDAY	SUNDAY
☐ Yes ☐ No ☐ ☺ ☐ ☹	☐ Yes ☐ No ☐ ☺ ☐ ☹	☐ Yes ☐ No ☐ ☺ ☐ ☹	☐ Yes ☐ No ☐ ☺ ☐ ☹
☐ Yes ☐ No (stop here)	☐ Yes ☐ No (stop here)	☐ Yes ☐ No (stop here)	☐ Yes ☐ No (stop here)
0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 17 19 20 21 22 23	0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 17 19 20 21 22 23	0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 17 19 20 21 22 23	0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 17 19 20 21 22 23
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No


auf

The following pages are due at a later date.

Possibly we will ask you again to fill out the diary after a later appointment – in this case you won't have to describe every day but only the days on which your headache occurs.

With this information, we will decide together how to move on during our next appointment!

Date:			
Did something special happen today? If yes, was it good ☺ or bad ☹? Describe briefly what happened.	☐ Yes ☐ No ☐ ☺ ☐ ☹	☐ Yes ☐ No ☐ ☺ ☐ ☹	☐ Yes ☐ No ☐ ☺ ☐ ☹
How strong has your headache been?	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
When did your headache occur? Mark all hours in which you had headache (each box stands for an hour) with an "x". Please also mark the box when you took medication with a "o".	0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 17 19 20 21 22 23	0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 17 19 20 21 22 23	0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 17 19 20 21 22 23
Did your headache get worse during exercises (e.g. climbing stairs, running, bouncing)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Did any other symptoms occur?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Did you feel nauseated?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Did you vomit?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Have you been sensitive to light?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Have you been sensitive to noise?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Have you been dizzy?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Did you have impaired vision?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Any other symptoms?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If so, which ones?			
Did you take medication because of your headache?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If so, which one?			
How effective was it? Please rate on a scale from 1–10 (0= not at all; 10= very effective).	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
Did you do something while you had headache (e.g. distraction, play, rest)?			
If so, how effective was it? Please rate on a scale from 1–10 (0= not at all; 10= very effective).	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
Did your headache keep you from school?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Or did your headache keep you from anything else (e.g. homework, sport, meeting friends)? If so, from what?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Has there been something special regarding your pain today?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If "no", great that you completed your headache diary! As reward you can paint, write, stamp or stick everything you like in this field.			

☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ ☺ ☐ ☹	☐ ☺ ☐ ☹	☐ ☺ ☐ ☹	☐ ☺ ☐ ☹
0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7
8 9 10 11 12 13 14 15	8 9 10 11 12 13 14 15	8 9 10 11 12 13 14 15	8 9 10 11 12 13 14 15
16 17 17 19 20 21 22 23	16 17 17 19 20 21 22 23	16 17 17 19 20 21 22 23	16 17 17 19 20 21 22 23
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Date:			
Did something special happen today? If yes, was it good ☺ or bad ☹? Describe briefly what happened.	☐ Yes ☐ No ☐ ☺ ☐ ☹	☐ Yes ☐ No ☐ ☺ ☐ ☹	☐ Yes ☐ No ☐ ☺ ☐ ☹
How strong has your headache been?	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
When did your headache occur? Mark all hours in which you had headache (each box stands for an hour) with an "x". Please also mark the box when you took medication with a "o".	0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 17 19 20 21 22 23	0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 17 19 20 21 22 23	0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 17 19 20 21 22 23
Did your headache get worse during exercises (e.g. climbing stairs, running, bouncing)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Did any other symptoms occur?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Did you feel nauseated?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Did you vomit?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Have you been sensitive to light?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Have you been sensitive to noise?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Have you been dizzy?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Did you have impaired vision?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Any other symptoms?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If so, which ones?			
Did you take medication because of your headache?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If so, which one?			
How effective was it? Please rate on a scale from 1–10 (0= not at all; 10= very effective).	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
Did you do something while you had headache (e.g. distraction, play, rest)?			
If so, how effective was it? Please rate on a scale from 1–10 (0= not at all; 10= very effective).	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
Did your headache keep you from school?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Or did your headache keep you from anything else (e.g. homework, sport, meeting friends)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If so, from what?			
Has there been something special regarding your pain today?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If "no", great that you completed your headache diary! As reward you can paint, write, stamp or stick everything you like in this field.			

☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ ☺ ☐ ☹	☐ ☺ ☐ ☹	☐ ☺ ☐ ☹	☐ ☺ ☐ ☹
0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7
8 9 10 11 12 13 14 15	8 9 10 11 12 13 14 15	8 9 10 11 12 13 14 15	8 9 10 11 12 13 14 15
16 17 17 19 20 21 22 23	16 17 17 19 20 21 22 23	16 17 17 19 20 21 22 23	16 17 17 19 20 21 22 23
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Date:			
Did something special happen today? If yes, was it good ☺ or bad ☹? Describe briefly what happened.	☐ Yes ☐ No ☐ ☺ ☐ ☹	☐ Yes ☐ No ☐ ☺ ☐ ☹	☐ Yes ☐ No ☐ ☺ ☐ ☹
How strong has your headache been?	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
When did your headache occur? Mark all hours in which you had headache (each box stands for an hour) with an "x". Please also mark the box when you took medication with a "o".	0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 17 19 20 21 22 23	0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 17 19 20 21 22 23	0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 17 19 20 21 22 23
Did your headache get worse during exercises (e.g. climbing stairs, running, bouncing)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Did any other symptoms occur?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Did you feel nauseated?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Did you vomit?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Have you been sensitive to light?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Have you been sensitive to noise?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Have you been dizzy?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Did you have impaired vision?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Any other symptoms?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If so, which ones?			
Did you take medication because of your headache?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If so, which one?			
How effective was it? Please rate on a scale from 1–10 (0= not at all; 10= very effective).	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
Did you do something while you had headache (e.g. distraction, play, rest)?			
If so, how effective was it? Please rate on a scale from 1–10 (0= not at all; 10= very effective).	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
Did your headache keep you from school?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Or did your headache keep you from anything else (e.g. homework, sport, meeting friends)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If so, from what?			
Has there been something special regarding your pain today?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If "no", great that you completed your headache diary! As reward you can paint, write, stamp or stick everything you like in this field.			

Yes No	Yes No	Yes No	Yes No
☺ ☹	☺ ☹	☺ ☹	☺ ☹
0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7
8 9 10 11 12 13 14 15	8 9 10 11 12 13 14 15	8 9 10 11 12 13 14 15	8 9 10 11 12 13 14 15
16 17 17 19 20 21 22 23	16 17 17 19 20 21 22 23	16 17 17 19 20 21 22 23	16 17 17 19 20 21 22 23
Yes No	Yes No	Yes No	Yes No
Yes No	Yes No	Yes No	Yes No
Yes No	Yes No	Yes No	Yes No
Yes No	Yes No	Yes No	Yes No
Yes No	Yes No	Yes No	Yes No
Yes No	Yes No	Yes No	Yes No
Yes No	Yes No	Yes No	Yes No
Yes No	Yes No	Yes No	Yes No
Yes No	Yes No	Yes No	Yes No
Yes No	Yes No	Yes No	Yes No
0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Yes No	Yes No	Yes No	Yes No
Yes No	Yes No	Yes No	Yes No
Yes No	Yes No	Yes No	Yes No


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DIARY

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TRÄGER:
VESTISCHE CARITAS-KLINIKEN GMBH