**HEADACHE DIARY (need to be attached with referral to be accepted)**

NAME: DATE OF BIRTH:

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| Day | Onset TimeStart?Finish? | SiteOrigin?Spread? | Character(describe whatthe headachefeels like) | Severity(1-10) | Nausea?(N)Vomiting?(V)Other symptoms?(eg dizzy?) | Pain ReliefName?Dose?Time?Response? | Otherrelievers? | Possible triggers?(eg Physical Activity? Posture? Food?Drink? Menstruation?) |
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