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

NAME: DATE OF BIRTH:

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| Day | Onset Time  Start?  Finish? | Site  Origin?  Spread? | Character  (describe what  the headache  feels like) | Severity  (1-10) | Nausea?(N)  Vomiting?(V)  Other symptoms?  (eg dizzy?) | Pain Relief  Name?  Dose?  Time?  Response? | Other  relievers? | Possible triggers?  (eg Physical Activity? Posture? Food?  Drink? Menstruation?) |
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