Migraine Tracker

A Comprehensive Diary for
Managing Migraine Symptoms

Migraine Tracker

A Comprehensive Diary for Managing Migraine Symptoms

INTRODUCTION

Migraine is more than just a headache. It is a complex condition that is often confused with ordinary headaches. It is important to make the distinction because migraine attacks significantly differ from regular headaches. While regular headaches are often experienced as temporary pain in the head, migraine can be accompanied by a wide range of symptoms, including pulsating headache, nausea, sensitivity to light and sound, and even visual disturbances.

This journal is designed to help you track, understand, and manage your migraine experiences. By documenting your migraine attacks and identifying triggers, you can work on finding ways to reduce the frequency and intensity of these attacks.

Within these pages, you will find a safe space to record your migraine journey. Here, you can note symptoms, identify triggers, track medication plans, and, perhaps most importantly, find a place to express your feelings.

Each page is an opportunity to reflect, learn, and grow. Whether you are just beginning to track your migraine attacks or have been living with this condition for years, this journal is your companion on the path to a better understanding and management of migraine. Migraine can be challenging, but it is also a part of who you are!

Date:_____

Sleep:_____ number of hours slept last night

My meal in the morning:_____

_____

_____

_____

_____

My meal in the afternoon:_____

_____

_____

_____

_____

My meal in the evening:_____

_____

_____

_____

_____

Snacks:

Water intake:

Today, I had a migraine attack: YES / NO

Time migraine attack started:

Time migraine attack ended:

Migraine symptoms:

Possible triggers of the migraine attack:_____

_____

_____

_____

_____

Medication taken:

Time:	Name of medication:	Dosage:

Other treatments:

Type of treatment:	Helped:

What is your overall well-being today:

(1)(2)(3)(4)(5)(6)(7)(8)(9)(10)

Notes about today: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Date:_____

Sleep:_____ number of hours slept last night

My meal in the morning:_____

_____

_____

_____

_____

My meal in the afternoon:_____

_____

_____

_____

_____

My meal in the evening:_____

_____

_____

_____

_____

Snacks:

Water intake:

Today, I had a migraine attack: YES / NO

Time migraine attack started:

Time migraine attack ended:

Migraine symptoms:

Possible triggers of the migraine attack:_____

_____

_____

_____

_____

Medication taken:

Time:	Name of medication:	Dosage:

Other treatments:

Type of treatment:	Helped:

What is your overall well-being today:

(1)(2)(3)(4)(5)(6)(7)(8)(9)(10)

Notes about today: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Date:_____

Sleep:_____ number of hours slept last night

My meal in the morning:_____

_____

_____

_____

_____

My meal in the afternoon:_____

_____

_____

_____

_____

My meal in the evening:_____

_____

_____

_____

_____

Snacks:_____

_____

_____

Water intake: _____

_____

_____

Today, I had a migraine attack: YES / NO _____

_____

Time migraine attack started:_____

_____

Time migraine attack ended:_____

_____

Migraine symptoms:_____

_____

_____

_____

_____

Possible triggers of the migraine attack:_____

_____

_____

_____

_____

Medication taken:

Time:	Name of medication:	Dosage:

Other treatments:

Type of treatment:	Helped:

What is your overall well-being today:

(1)(2)(3)(4)(5)(6)(7)(8)(9)(10)

Notes about today: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Date:_____

Sleep:_____ number of hours slept last night

My meal in the morning:_____

_____

_____

_____

_____

My meal in the afternoon:_____

_____

_____

_____

_____

My meal in the evening:_____

_____

_____

_____

_____

Snacks:_____

_____

_____

Water intake: _____

_____

_____

Today, I had a migraine attack: YES / NO _____

_____

Time migraine attack started:_____

_____

Time migraine attack ended:_____

_____

Migraine symptoms:_____

_____

_____

_____

_____

Possible triggers of the migraine attack:_____

_____

_____

_____

_____

Medication taken:

Time:	Name of medication:	Dosage:

Other treatments:

Type of treatment:	Helped:

What is your overall well-being today:

(1)(2)(3)(4)(5)(6)(7)(8)(9)(10)

Notes about today: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Date:_____

Sleep:_____ number of hours slept last night

My meal in the morning:_____

_____

_____

_____

_____

My meal in the afternoon:_____

_____

_____

_____

_____

My meal in the evening:_____

_____

_____

_____

_____

Snacks:_____

_____

_____

Water intake: _____

_____

_____

Today, I had a migraine attack: YES / NO _____

_____

Time migraine attack started:_____

_____

Time migraine attack ended:_____

_____

Migraine symptoms:_____

_____

_____

_____

_____

Possible triggers of the migraine attack:_____

_____

_____

_____

_____

Medication taken:

Time:	Name of medication:	Dosage:

Other treatments:

Type of treatment:	Helped:

What is your overall well-being today:

(1)(2)(3)(4)(5)(6)(7)(8)(9)(10)

Notes about today: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Date:_____

Sleep:_____ number of hours slept last night

My meal in the morning:_____

_____

_____

_____

_____

My meal in the afternoon:_____

_____

_____

_____

_____

My meal in the evening:_____

_____

_____

_____

_____