



MIGRAINE CALENDAR

Name: _____ DOB: _____

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Record:

1. MIGRAINES - The days you have a migraine.
2. SEVERITY - The intensity of your migraine (using 1-10 pain scale).
3. ACUTE THERAPY - The treatment you used and whether it was effective or not.
4. PREVENTATIVE THERAPY - You may also choose to use this calendar to track your daily, preventative medications.



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