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