Migraine Episode Documentation Template

Date of Episode: ____________________________

Time of Onset: ____________________________

Duration: _______________________________

Symptoms Experienced:

- Headache Severity (1-10): _______________
- Type of Pain (e.g., throbbing, constant): _______________
- Location of Pain: ____________________________
- Nausea (Yes/No): ____________________________
- Visual Disturbances (Yes/No): ____________________________
- Other Symptoms: ____________________________

Triggers (if known):

- Stress: ________________________
- Food: __________________________
- Weather: ______________________
- Other: __________________________

Treatment Administered:

- Medications Taken: ____________________________
- Other Remedies: ____________________________
- Effectiveness (1-10): _______________

Aftercare Notes:

Follow-up Actions: ______________________________

Additional Comments: ____________________________

Prepared by: ____________________________

Date: ____________________________