

# DAILY HEADACHE SELF-MONITORING FORM

NAME:	SOCIAL SECURITY NUMBER:	PATIENT ID NUMBER:
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**DIRECTIONS:** Four times each day, please rate your headache intensity, disability level, and stress using the rating scales below. Mark the times that you were sleeping and eating by coloring (or putting x) in the boxes. You may indicate ½ hour increments by coloring ½ of a box (or use slash). Also, record body temperature, whether menstruating, and ratings of sleep amount and sleep quality.

HEADACHE INTENSITY	DISABILITY	STRESS	SLEEP AMOUNT	SLEEP QUALITY
10 EXTREMELY PAINFUL.....My headache is so painful that I can't do anything. 9 8 VERY PAINFUL.....My headache makes concentration difficult, but I can perform demanding tasks. 7 6 PAINFUL.....My headache is painful, but I can continue what I am doing. 5 4 MILDLY PAINFUL.....I can ignore my headache most of the time. 3 2 SLIGHTLY PAINFUL.....I only notice my headache when I focus my attention on it. 1 0 NO HEADACHE	10 COMPLETELY IMPAIRED (Bedrest) 9 8 SEVERELY IMPAIRED 7 6 MODERATELY IMPAIRED 5 4 MILDLY IMPAIRED 3 2 MINIMALLY IMPAIRED 1 0 NO IMPAIRMENT	10 EXTREMELY 9 8 VERY 7 6 MODERATELY 5 4 MILDLY 3 2 SLIGHTLY 1 0 NO STRESS	10 TOO MUCH 9 8 7 6 5 PERFECT 4 3 2 1 0 TOO LITTLE	10 EXCELLENT 9 8 VERY GOOD 7 6 GOOD 5 4 FAIR 3 2 POOR 1 0 VERY POOR

**WEEKLY MEDICATION LIST (AND AMOUNT):**

<b>MONDAY</b>	DATE:	12a	1a	2a	3a	4a	5a	6a	7a	8a	9a	10a	11a	12p	1p	2p	3p	4p	5p	6p	7p	8p	9p	10p	11p	TEMP
	HEADACHE:																									MENSES Y - N
	DISABILITY:																									SLEEP AMOUNT
	STRESS:																									
	SLEEP:																									
	MEAL/SNACK:																									
	MEDICATION (AND AMOUNT):																COMMENTS:						SLEEP QUALITY			

<b>TUESDAY</b>	DATE:	12a	1a	2a	3a	4a	5a	6a	7a	8a	9a	10a	11a	12p	1p	2p	3p	4p	5p	6p	7p	8p	9p	10p	11p	TEMP
	HEADACHE:																									MENSES Y - N
	DISABILITY:																									SLEEP AMOUNT
	STRESS:																									
	SLEEP:																									
	MEAL/SNACK:																									
	MEDICATION (AND AMOUNT):																COMMENTS:						SLEEP QUALITY			

<b>WEDNESDAY</b>	DATE:	12a	1a	2a	3a	4a	5a	6a	7a	8a	9a	10a	11a	12p	1p	2p	3p	4p	5p	6p	7p	8p	9p	10p	11p	TEMP
	HEADACHE:																									MENSES Y - N
	DISABILITY:																									SLEEP AMOUNT
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	SLEEP:																									
	MEAL/SNACK:																									
	MEDICATION (AND AMOUNT):																COMMENTS:						SLEEP QUALITY			

**NAME:** \_\_\_\_\_ **DIRECTIONS:** Four times each day, please rate your headache intensity, disability level, and stress using the rating scales below. Mark the times that you were sleeping and eating by coloring (or putting x) in the boxes. You may indicate ½ hour increments by coloring ½ of a box (or use slash). Also, record body temperature, whether menstruating, and ratings of sleep amount and sleep quality.

HEADACHE INTENSITY		DISABILITY		STRESS		SLEEP AMOUNT		SLEEP QUALITY	
10	EXTREMELY PAINFUL.....My headache is so painful that I can't do anything.	10	COMPLETELY IMPAIRED (Bedrest)	10	EXTREMELY	10	TOO MUCH	10	EXCELLENT
9		9		9		9		9	
8	VERY PAINFUL.....My headache makes concentration difficult, but I can perform demanding tasks.	8	SEVERELY IMPAIRED	8	VERY	8		8	VERY GOOD
7		7		7		7		7	
6	PAINFUL.....My headache is painful, but I can continue what I am doing.	6	MODERATELY IMPAIRED	6	MODERATELY	6		6	GOOD
5		5		5		5	PERFECT	5	
4	MILDLY PAINFUL.....I can ignore my headache most of the time.	4	MILDLY IMPAIRED	4	MILDLY	4		4	FAIR
3		3		3		3		3	
2	SLIGHTLY PAINFUL.....I only notice my headache when I focus my attention on it.	2	MINIMALLY IMPAIRED	2	SLIGHTLY	2		2	POOR
1		1		1		1		1	
0	NO HEADACHE	0	NO IMPAIRMENT	0	NO STRESS	0	TOO LITTLE	0	VERY POOR

<b>THURSDAY</b>	<b>DATE:</b> _____	12a	1a	2a	3a	4a	5a	6a	7a	8a	9a	10a	11a	12p	1p	2p	3p	4p	5p	6p	7p	8p	9p	10p	11p	<b>TEMP</b>
	<b>HEADACHE:</b>																									<b>MENSES</b>
	<b>DISABILITY:</b>																									<b>Y - N</b>
	<b>STRESS:</b>																									<b>SLEEP AMOUNT</b>
	<b>SLEEP:</b>																									<b>SLEEP QUALITY</b>
	<b>MEAL/SNACK:</b>																									
<b>MEDICATION (AND AMOUNT):</b> _____															<b>COMMENTS:</b> _____											

<b>FRIDAY</b>	<b>DATE:</b> _____	12a	1a	2a	3a	4a	5a	6a	7a	8a	9a	10a	11a	12p	1p	2p	3p	4p	5p	6p	7p	8p	9p	10p	11p	<b>TEMP</b>
	<b>HEADACHE:</b>																									<b>MENSES</b>
	<b>DISABILITY:</b>																									<b>Y - N</b>
	<b>STRESS:</b>																									<b>SLEEP AMOUNT</b>
	<b>SLEEP:</b>																									<b>SLEEP QUALITY</b>
	<b>MEAL/SNACK:</b>																									
<b>MEDICATION (AND AMOUNT):</b> _____															<b>COMMENTS:</b> _____											

<b>SATURDAY</b>	<b>DATE:</b> _____	12a	1a	2a	3a	4a	5a	6a	7a	8a	9a	10a	11a	12p	1p	2p	3p	4p	5p	6p	7p	8p	9p	10p	11p	<b>TEMP</b>
	<b>HEADACHE:</b>																									<b>MENSES</b>
	<b>DISABILITY:</b>																									<b>Y - N</b>
	<b>STRESS:</b>																									<b>SLEEP AMOUNT</b>
	<b>SLEEP:</b>																									<b>SLEEP QUALITY</b>
	<b>MEAL/SNACK:</b>																									
<b>MEDICATION (AND AMOUNT):</b> _____															<b>COMMENTS:</b> _____											

<b>SUNDAY</b>	<b>DATE:</b> _____	12a	1a	2a	3a	4a	5a	6a	7a	8a	9a	10a	11a	12p	1p	2p	3p	4p	5p	6p	7p	8p	9p	10p	11p	<b>TEMP</b>
	<b>HEADACHE:</b>																									<b>MENSES</b>
	<b>DISABILITY:</b>																									<b>Y - N</b>
	<b>STRESS:</b>																									<b>SLEEP AMOUNT</b>
	<b>SLEEP:</b>																									<b>SLEEP QUALITY</b>
	<b>MEAL/SNACK:</b>																									
<b>MEDICATION (AND AMOUNT):</b> _____															<b>COMMENTS:</b> _____											

# Instructions for Daily Headache Self-Monitoring Form

## *Self-Management Training Program for Chronic Headache*

These forms are designed to help you keep a careful record of your: daily headache intensity levels, stress, disability, medication use, meal pattern, sleep (pattern, quality, amount), basal temperature (women only), and menses (women only). Each page contains seven grids -- one for each day of the week. You may want to fold the sheet so you can carry it with you in your pocket or purse. Each grid has several spaces running horizontally that correspond with times of the day (12am to 11pm) for each day of the week. These boxes will be used to keep track of headache intensity, disability, stress, sleep, and meals. On top of the page are rating scales for headache intensity, disability, stress, sleep amount, and sleep quality. There is a large box at the top of the front page for listing medications that you take weekly. There are also boxes for keeping track of daily medications that are not used regularly. And finally, there is space available for making daily comments on any day of the week.

We would like you to rate each day's headache intensity, disability, and stress at least four times each day. Most people find it easiest to make ratings at the same times each day. People also find it helpful to pair the act of recording with some other daily event to help them remember to record. For example, you might record (1) at breakfast or when you first get up, (2) at lunch time or when you hear noon church bells, (3) at supper time or when you first get home from work or school, and (4) at bedtime or when your favorite evening TV show begins. If you should happen to forget to make a recording at your usual time, please fill in the grid just as soon as you remember. In addition, whenever you take medication for a headache, please indicate the amount and type of medication in the space provided for that day.

Each time you update the grid put the ratings in the boxes that correspond to the time of day that you are rating. For example, if you are making ratings for 6am Monday, then indicate the level of your headache, disability, and stress in the boxes of the column for 6am Monday. Put the number in the box that best describes how you are feeling at that time. For headache intensity you will put a number from 0 (*NO HEADACHE*) to 10 (*EXTREMELY PAINFUL HEADACHE*), for disability level you will put a number from 0 (*NO IMPAIRMENT*) to 10 (*COMPLETELY IMPAIRED*), and for stress you will put a number from 0 (*NO STRESS*) to 10 (*EXTREMELY STRESSED*). Don't be overly concerned with the exact rating level you select; your first impression is probably the best estimate. If you have a day with no headache, please be sure to complete the grid anyway. To indicate your sleeping pattern, you will place an "X" in the boxes that correspond with times that you were asleep. If you slept for only half of the hour, then place a "/" in the box. For indicating meals and snacks, place an "X" in the hourly boxes that correspond with times of the day that you ate a meal or a snack.

Also, once a day you will rate your sleep amount and your sleep quality in the single boxes to the right of each day's grid. When you rate your sleep amount, you will place the number corresponding to how much you think you slept from 0 (*TOO LITTLE*) to 10 (*TOO MUCH*). When you make this rating, we want you to tell us what you feel about your sleep amount, not how much experts tell you you should have. For example, some people might sleep 8 hours, but still feel like it was too little. On the other hand, other people might sleep 8 hours and think it was too much. Additionally, you will rate

your sleep quality by placing the number corresponding to your experience ranging from 0 (*VERY POOR*) to 10 (*EXCELLENT*).

### **EXAMPLE FORM:**

At the bottom of this page is an example. You can see that on Monday, Marcy reported NO HEADACHE (intensity 0) at 6:00 am when she got up. At noon, she had a SLIGHTLY PAINFUL (intensity 2) headache, by supper time (6:00 pm) she reported a PAINFUL (intensity 6) headache, and just before bed (10:30 pm) it had decreased to SLIGHTLY PAINFUL (intensity 2). Her level of disability was the same throughout the day, MINIMALLY IMPAIRED (2) at 6:00 am, 12:00 pm, 6:00 pm, and 10:30 pm. But, Marcy has a stressful job, so her stress level decreased after she came home from work. It started out as VERY STRESSED (8) when she awoke (9:00 am) and remained high at noon. Her stress dropped by supper (6:00 pm) to SLIGHTLY (2) and she experienced NO STRESS (0) as she went to sleep (10:30 pm).

To indicate that she awoke at 6:00 am, she marked an "X" in the boxes corresponding to 12am, 1am, 2am, 3am, 4am, and 5am. She took a 30 min nap at 7:30 pm, so she put a "/" mark in the sleep box corresponding to 7:00 pm. She fell asleep at 10:30, so she put a "/" mark in the sleep box for 10:00 pm, and an "X" in the sleep box corresponding to 11pm. She ate breakfast at 7:00 am, lunch at 12:00 pm, a snack at 3:00 pm, and supper at 6:00 pm. Therefore, she placed "X"s in the meal/snack boxes for 7am, 12pm, 3pm, and 6pm.

Upon waking, Marcy took her body temperature and found that it was 98.6°, so she indicated this in the box marked "TEMP." Since she was not menstruating on Monday, she circled the "N." Marcy also made a subjective rating of her sleep amount by putting a 3 in that box, indicating it was somewhat too little. She thought the sleep that she did get was FAIR, so she placed a "4" in the box for "SLEEP QUALITY".

Marcy took 2 aspirin and 1 butalbital (50 mg) for her headache on Monday. She also noted in the comments box that her nap seemed to help reduce her headache intensity.

When filling out each grid, please be sure to write your name and the dates of the week on each page. If you have any questions about these recording procedures, feel free to call and ask for advice.