Headache Center
NeuroMusculoskeletal Institute (NMI)
42 E. Laurel Road, UDP1700, Stratford, NJ 08084
856-566-7010 (telephone) * 856-566-6956 (fax)

Name: ________________________________
D.O.B. ________________________________
Month/Year: ___________________________

OMT Provider ____________________________
**Mark Day Of Manipulation Therapy Below

This calendar is numbered 1 - 31 for each day of the month. On the days you have headache pain, record in the box the number that describes your headache pain and disability.

(*) Pain Intensity

0 = no pain
1 = mild pain
2 = moderate pain
3 = severe pain

(**) Disability

0 = normal functioning
1 = mild impairment
2 = moderate impairment
3 = severe impairment
4 = requires bed rest at least part of the day

Calendar Day of Month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Pain Intensity* (0-3)																															
in Morning																															
in Afternoon																															
in Evening/Night																															
***Disability** (0-4) for the day**																															
Check Days of Menses																															

On the days you take medicines to relieve your headache pain, write the name of the medicines and the doses in the appropriate box. Place a check for each dose you take.
Also, record a number from 0 – 3 that describes the amount of **overall relief** you got from the medicine: **0 = no relief; 1 = slight relief; 2 = moderate relief; 3 = complete relief.**
Do not record your daily preventive medications.

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"As needed" medication																															
Medicine:																															
____________Overall Relief:																															
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***************OMT SESSIONS***																															

OVERALL SEVERITY OF HEADACHE CONDITION FOR THIS MONTH:

No Problems — Almost Unbearable

0	1	2	3	4	5	6	7	8	9	10