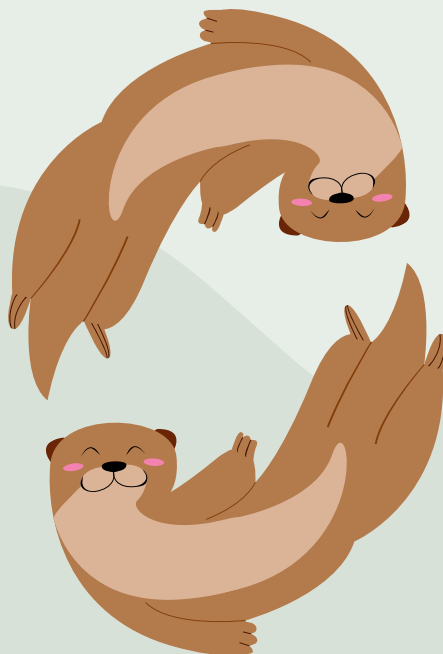


Willow Therapies

Awareness

Journal for Migraine Relief

For the naturally cycling, pre-menopausal female.



Everyone has a natural healing ability.
This journal is one step in helping to
unlock and enhance your
self-healing ability.



colour me!

Initial Assessment

Number of days with a migraine/headache in the past 30 days:

Thinking of your migraine/headache days in the past 30 days, rate the pain, fatigue, and nausea levels of these acute attacks. Every 30 days review the overall intensity of these symptoms.

1. Pain

Low/None (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) High/Worst

2. Fatigue

Low/None (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) High/Worst

3. Nausea

Low/None (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) High/Worst

Vitamins/Supplements: _____

GOALS

Start with 1 - 3 small changes or microhabits. Are you wanting to introduce some more movement? A daily preventative practice, change how you eat? Note it here, then check off the corresponding box on each days journal page.

GOAL A _____

GOAL B _____

GOAL C _____

Date:

Goals:

 A B C

General Health

Meals/Snacks: _____

Beverages (incl. alcohol): _____

Water intake: 1 2 3 4 5 6 7 8 9 10 11 12 cups

Physical Activity: _____

Sleep: _____ hrs, quality: low med high Stress levels: low 1 2 3 4 5 6 7 8 9 10 high

Cycle Day: _____ Menstruation/Bleeding: Spotting Light Medium Heavy

External Stressors

Symptoms Experienced

___ Weather

___ Headache

___ Increased Urination

___ Allergies

___ Fatigue

___ Depression

___ Eye Strain

___ Irritability

___ Sensitivity to light/sound

___ Tight/Sore Muscles

___ Poor Sleep

___ Trouble Concentrating

___ Illness

___ Nausea

___ Bloating

___ Other:

___ Anxiety

___ Other:

Migraine/Headache

Yes No

**If Yes please*

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at back

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- | | | |
|---|---------------------------------------|---|
| <input type="checkbox"/> Weather | <input type="checkbox"/> Headache | <input type="checkbox"/> Increased Urination |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Eye Strain | <input type="checkbox"/> Irritability | <input type="checkbox"/> Sensitivity to light/sound |
| <input type="checkbox"/> Tight/Sore Muscles | <input type="checkbox"/> Poor Sleep | <input type="checkbox"/> Trouble Concentrating |
| <input type="checkbox"/> Illness | <input type="checkbox"/> Nausea | <input type="checkbox"/> Bloating |
| <input type="checkbox"/> Other: | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Other: |

Migraine/Headache

Yes No
**If Yes please
fill out
'Migraine Log'
at back*

30 Day Review

Number of days with a migraine/headache in the past 30 days:

Thinking of your migraine/headache days in the past 30 days, rate the pain, fatigue, and nausea levels of these acute attacks. Every 30 days review the overall intensity of these symptoms.

1. Pain

Low/None (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) High/Worst

2. Fatigue

Low/None (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) High/Worst

3. Nausea

Low/None (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) High/Worst

Vitamins/Supplements: _____

GOALS

Start with 1 - 3 small changes or microhabits. Are you wanting to introduce some more movement? A daily preventative practice, change how you eat? Note it here, then check off the corresponding box on each days journal page.

GOAL A _____

GOAL B _____

GOAL C _____

Date:

Goals:

A B C

General Health

Meals/Snacks: _____

Beverages (incl. alcohol): _____

Water intake: 1 2 3 4 5 6 7 8 9 10 11 12 cups

Physical Activity: _____

Sleep: _____ hrs, quality: low med high Stress levels: low 1 2 3 4 5 6 7 8 9 10 high

Cycle Day: _____ Menstruation/Bleeding: Spotting Light Medium Heavy

External Stressors

Symptoms Experienced

___ Weather

___ Headache ___ Increased Urination

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___ Eye Strain

___ Irritability ___ Sensitivity to light/sound

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Migraine/Headache

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Low/None (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) High/Worst

2. Fatigue

Low/None (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) High/Worst

3. Nausea

Low/None (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) High/Worst

Vitamins/Supplements: _____

GOALS

Start with 1 - 3 small changes or microhabits. Are you wanting to introduce some more movement? A daily preventative practice, change how you eat? Note it here, then check off the corresponding box on each days journal page.

GOAL A _____

GOAL B _____

GOAL C _____

Date:

Goals:

A B C

General Health

Meals/Snacks: _____

Beverages (incl. alcohol): _____

Water intake: 1 2 3 4 5 6 7 8 9 10 11 12 cups

Physical Activity: _____

Sleep: _____ hrs, quality: low med high Stress levels: low 1 2 3 4 5 6 7 8 9 10 high

Cycle Day: _____ Menstruation/Bleeding: Spotting Light Medium Heavy

External Stressors

Symptoms Experienced

___ Weather

___ Headache ___ Increased Urination

___ Allergies

___ Fatigue ___ Depression

___ Eye Strain

___ Irritability ___ Sensitivity to light/sound

___ Tight/Sore Muscles

___ Poor Sleep ___ Trouble Concentrating

___ Illness

___ Nausea ___ Bloating

___ Other:

___ Anxiety ___ Other:

Migraine/Headache

Yes No

**If Yes please
fill out*

*'Migraine Log'
at back*

Date:

Goals:

A B C

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Meals/Snacks: _____

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Migraine/Headache

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at back*

30 Day Review

Number of days with a migraine/headache in the past 30 days:

Thinking of your migraine/headache days in the past 30 days, rate the pain, fatigue, and nausea levels of these acute attacks. Every 30 days review the overall intensity of these symptoms.

1. Pain

Low/None (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) High/Worst

2. Fatigue

Low/None (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) High/Worst

3. Nausea

Low/None (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) High/Worst

Vitamins/Supplements: _____

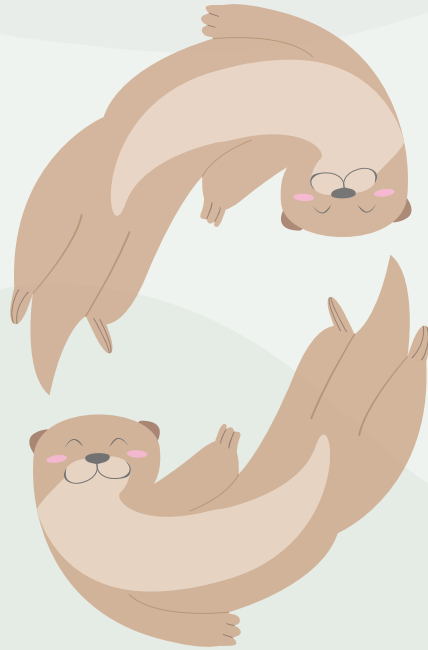
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GOAL A _____

GOAL B _____

GOAL C _____



Willow Therapies
Willowtherapies.ca
Headingley, MB, Canada