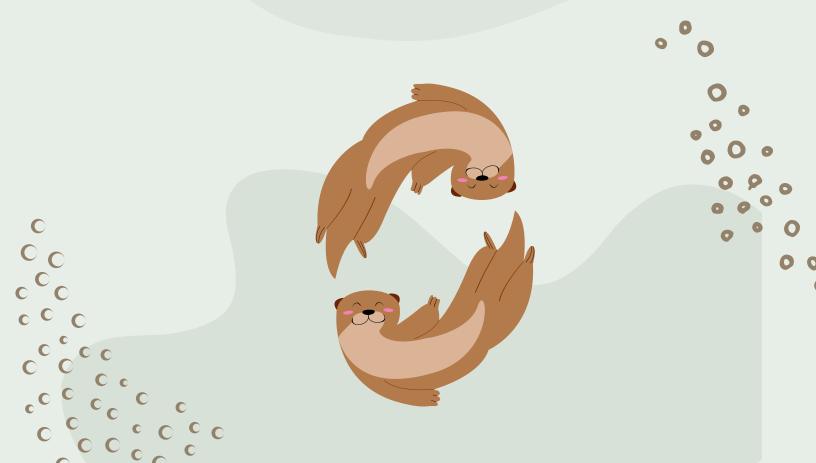
Willow Therapies

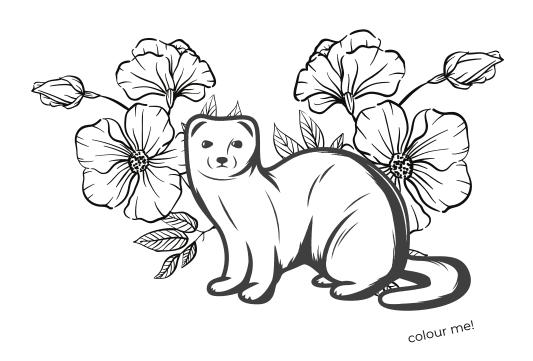
# Awareness

## 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.

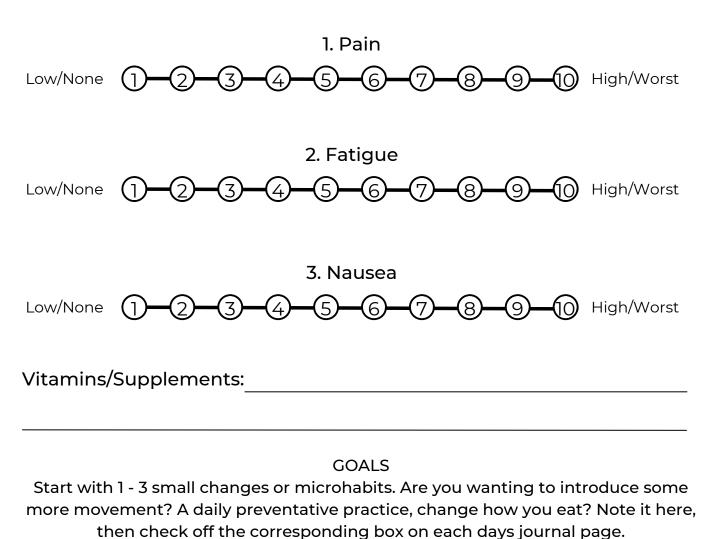


#### Initial Assessment

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

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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.



GOAL A

GOAL B

GOAL C

#### **Initial Assessment**

Notes - have you introduced any diet or lifestyle changes? Tried a supportive therapy? Has any preventative care this past 30 days been helpful? Write it down here.

Date:	Goals:	A□ B□ C□			
General Health  Meals/Snacks:					
Beverages (incl. alchohol)	:				
Water intake: 1 2 3 4 5 6 Physical Activity:	5 7 8 9 10 11 12 cups				
	ow med high Stress levels: low				
Cycle Day: Mens	struation/Bleeding: Spotting 🗆 l	Light □ Medium □ Heavy □			
External Stressors Sy	mptoms Experienced				
Allergies Eye Strain Tight/Sore Muscles Illness	_ Headache Increased Urina _ Fatigue Depression _ Irritability Sensitivity to lig _ Poor Sleep Trouble Concer _ Nausea Bloating _ Anxiety Other:	yes □ No □  ght/sound *If Yes please			
Date: Goals: A B C					
Meals/Snacks:	General Health  Meals/Snacks:				
Beverages (incl. alchohol)	:				
Water intake: 1 2 3 4 5 6 7 8 9 10 11 12 cups					
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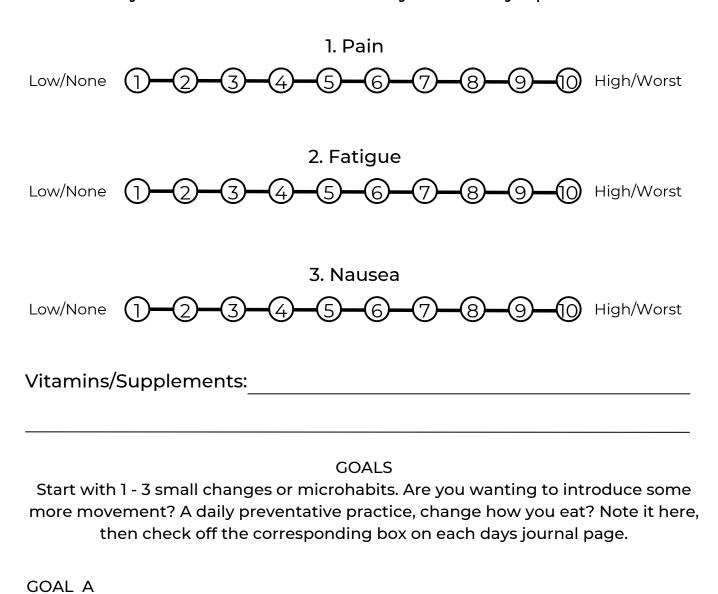
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#### 30 Day Review

	Number of days with	a migraine/	headache in tl	he past 30 days:
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\_\_\_\_

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.



GOAL B

GOAL C

### 30 Day Review

Notes - have you introduced any diet or lifestyle changes? Tried a supportive therapy? Has any preventative care this past 30 days been helpful? Write it down here.			

Date:	Goals:	A□ B□ C□	
Meals/Snacks:	General Health		
Beverages (incl. alchohol):			
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Date: Goals: A B C			
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Sleep: hrs, quality: low med high  Cycle Day: Menstruation/Bleeding: Spotting □ Light □ Medium □ Heavy □			
External Stressors Symptoms Experienced			
<ul><li>Weather</li><li>Allergies</li><li>Eye Strain</li><li>Tight/Sore Muscles</li><li>Illness</li></ul>	Headache Increased Urina Fatigue Depression Irritability Sensitivity to lig Poor Sleep Trouble Concer Nausea Bloating Anxiety Other:	Yes □ No □ ght/sound *If Yes please	

Date:	Goals:	A□ B	□ C□
General Health  Meals/Snacks:			
Beverages (incl. alchohol): _			
Water intake: 1 2 3 4 5 6 ' Physical Activity:	7 8 9 10 11 12 cups		
Sleep: hrs, quality: low	med high Stress levels: low	/123456	5 7 8 9 10 high
Cycle Day: Menstr	uation/Bleeding: Spotting 🗆	Light □ Mec	lium □ Heavy □
External Stressors Sym	ptoms Experienced	I	
Allergies   Eye Strain   Tight/Sore Muscles   Illness	Headache Increased Urina Fatigue Depression rritability Sensitivity to lig Poor Sleep Trouble Conce Nausea Bloating Anxiety Other:	ght/sound	Migraine/Headache  Yes □ No □ *If Yes please fill out 'Migraine Log' at back
Date: Goals: A B C			
Meals/Snacks:	General Health		
Beverages (incl. alchohol):			
Water intake: 1 2 3 4 5 6 7 8 9 10 11 12 cups			
Physical Activity:			
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Date:	Goals:	A□ B□ C□	
General Health  Meals/Snacks:			
Beverages (incl. alchohol	):		
Water intake: 1 2 3 4 5 Physical Activity:	6 7 8 9 10 11 12 cups		
	ow med high Stress levels: low		
Cycle Day: Men	struation/Bleeding: Spotting 🛭 I	Light □ Medium □ Heavy □	
External Stressors Sy	ymptoms Experienced		
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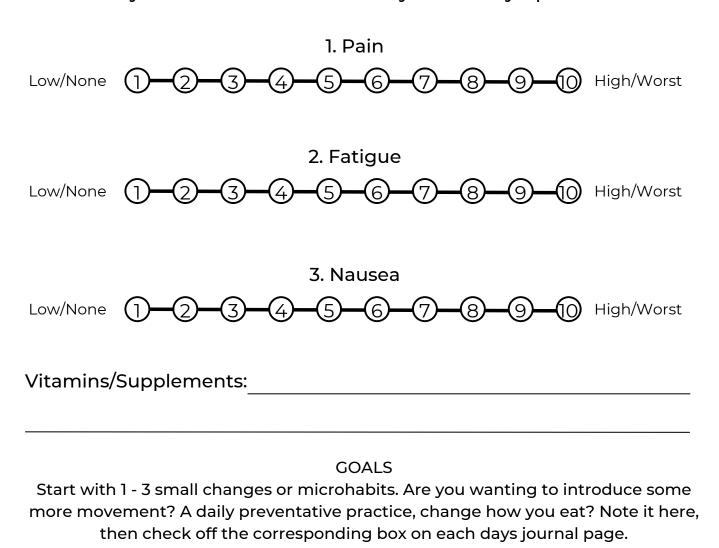
Date:	Goals:	A□ B□ C□	
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Number of days with a mig	raine/headache in	the past 30 days:
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\_\_\_\_\_

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.



GOAL A

GOAL B

**GOAL C** 

Notes - have you introduced any diet or lifestyle changes? Tried a supportive therapy? Has any preventative care this past 30 days been helpful? Write it down here.		

Date:	Goals:	A□ B□ C□	
General Health  Meals/Snacks:			
Beverages (incl. alchohol):			
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Sleep: hrs, quality: low med high  Cycle Day: Menstruation/Bleeding: Spotting □ Light □ Medium □ Heavy □			
External Stressors Symptoms Experienced			
<ul><li>Weather</li><li>Allergies</li><li>Eye Strain</li><li>Tight/Sore Muscles</li><li>Illness</li></ul>	Headache Increased Urina Fatigue Depression Irritability Sensitivity to lig Poor Sleep Trouble Concer Nausea Bloating Anxiety Other:	Yes □ No □ ght/sound *If Yes please	

Date:	Goals:	A□ B□ C□		
General Health  Meals/Snacks:				
Beverages (incl. alchohol)	:			
Water intake: 1 2 3 4 5 6 Physical Activity:	5 7 8 9 10 11 12 cups			
	ow med high Stress levels: low			
Cycle Day: Mens	struation/Bleeding: Spotting 🗆 l	Light □ Medium □ Heavy □		
External Stressors Sy	mptoms Experienced			
Allergies Eye Strain Tight/Sore Muscles Illness	_ Headache Increased Urina _ Fatigue Depression _ Irritability Sensitivity to lig _ Poor Sleep Trouble Concer _ Nausea Bloating _ Anxiety Other:	yes □ No □  ght/sound *If Yes please		
Date: Goals: A B C				
General Health  Meals/Snacks:				
Beverages (incl. alchohol)	Beverages (incl. alchohol):			
Water intake: 1 2 3 4 5 6 7 8 9 10 11 12 cups				
Physical Activity:				
Sleep: hrs, quality: low med high  Cycle Day: Menstruation/Bleeding: Spotting □ Light □ Medium □ Heavy □				
External Stressors Symptoms Experienced				
Weather Allergies Eye Strain Tight/Sore Muscles Illness	_ Headache Increased Urina _ Fatigue Depression _ Irritability Sensitivity to lig _ Poor Sleep Trouble Concer _ Nausea Bloating _ Anxiety Other:	yes □ No □  ght/sound *If Yes please		

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General Health  Meals/Snacks:			
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External Stressors Syr	mptoms Experienced		
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External Stressors Symptoms Experienced			
<ul><li>Weather</li><li>Allergies</li><li>Eye Strain</li><li>Tight/Sore Muscles</li><li>Illness</li></ul>	Headache Increased Urina Fatigue Depression Irritability Sensitivity to lig Poor Sleep Trouble Concer Nausea Bloating Anxiety Other:	Yes □ No □ ght/sound *If Yes please	

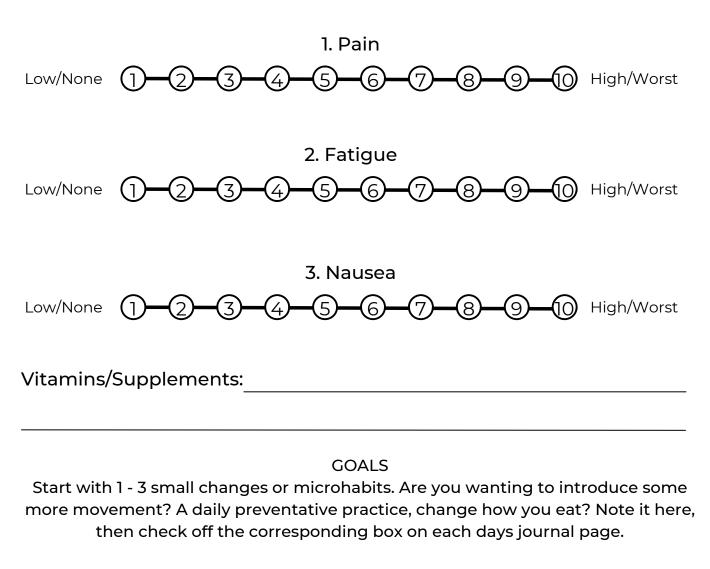
Date:	Goals:	A□ B□ C□		
General Health  Meals/Snacks:				
Beverages (incl. alchohol)	:			
Water intake: 1 2 3 4 5 6 Physical Activity:	5 7 8 9 10 11 12 cups			
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Date: Goals: A B C				
General Health  Meals/Snacks:				
Beverages (incl. alchohol)	Beverages (incl. alchohol):			
Water intake: 1 2 3 4 5 6 7 8 9 10 11 12 cups				
Physical Activity:				
Sleep: hrs, quality: low med high  Cycle Day: Menstruation/Bleeding: Spotting □ Light □ Medium □ Heavy □				
External Stressors Symptoms Experienced				
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Date:	Goals:	A□ B□ C□		
General Health  Meals/Snacks:				
Beverages (incl. alchohol)	:			
Water intake: 1 2 3 4 5 6 Physical Activity:	5 7 8 9 10 11 12 cups			
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Date: Goals: A B C				
General Health  Meals/Snacks:				
Beverages (incl. alchohol)	Beverages (incl. alchohol):			
Water intake: 1 2 3 4 5 6 7 8 9 10 11 12 cups				
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Number of days with a migraine/he	eadache in the past 30 days:
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\_\_\_\_

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.



GOAL B
GOAL C

supportive therapy? Has any preventative care this past 30 days bee		
helpful? Write it down here.		

Date	Start	End	Duration	Location	Intensity /10	Aura y/n	Medication Taken	Self Care Measures Used

Date	Start	End	Duration	Location	Intensity /10	Aura y/n	Medication Taken	Self Care Measures Used

3	3		

Date	Start	End	Duration	Location	Intensity /10	Aura y/n	Medication Taken	Self Care Measures Used

Date	Start	End	Duration	Location	Intensity /10	Aura y/n	Medication Taken	Self Care Measures Used

