NW Headache and Wellness Center, PC

Dale M. Carter, MD

Diary/Month:_____ Patient Name:_____ Date of Birth:_____

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
Date: _____ HA type: Treatment: Triggers:	Date: _____ HA type: Treatment: Triggers:	Date: _____ HA type: Treatment: Triggers:	Date: _____ HA type: Treatment: Triggers:	Date: _____ HA type: Treatment: Triggers:	Date: _____ HA type: Treatment: Triggers:	Date: _____ HA type: Treatment: Triggers:
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