Name:							On Location note Right, Left or Both				
Date	Migraine Y or N	Time Began	Time End	Total Time	Intensity 0-10	Medication & Amount	Behind/Around Eye	Temple	Above Eyebrows	Back Head/Neck	Other Location
example	Y	7:00am	9:00am	2 hrs	8	Imitrex 2 tab	Start- Both	2nd Right	0	0	cheeks
Totals											