

Tension Headache Treatment

Patient information

Name:

Date of birth:

Gender:

Contact information:

Medical history:

Tension headache symptoms

Frequency:

Duration:

Intensity:

Location:

Description:

Potential triggers

Stress:

Caffeine:

Sleep patterns:

Physical activity:

Diet:

Treatment plan

Medications:

Lifestyle modifications:

Therapies:

Follow-up plan

Next appointment:

Additional notes and recommendations:

Emergency contact information:

Healthcare practitioner's information

Name:

Signature:

Date: