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: