

# Yearly Headache Tracker

[illegible]

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES



DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END
DURATION	

SEVERITY	SINUS	WEATHER
1	<input type="checkbox"/>	<input type="checkbox"/>
2	<input type="checkbox"/>	<input type="checkbox"/>
3	<input type="checkbox"/>	<input type="checkbox"/>
4	<input type="checkbox"/>	<input type="checkbox"/>
5	<input type="checkbox"/>	<input type="checkbox"/>
	CLUSTER	
	TMJ	
	MIGRAINE	
	TENSION	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES



DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
			CLUSTER	
			TMJ	
			MIGRAINE	
			TENSION	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
			CLUSTER	
			TMJ	
			MIGRAINE	
			TENSION	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
			CLUSTER	
			TMJ	
			MIGRAINE	
			TENSION	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES



DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
			CLUSTER	
			TMJ	
			MIGRAINE	
			TENSION	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES



DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY..... DATE:...../...../.....

START	END
DURATION	

SEVERITY	SINUS	WEATHER
1	<input type="checkbox"/>	<input type="checkbox"/>
2	<input type="checkbox"/>	<input type="checkbox"/>
3	<input type="checkbox"/>	<input type="checkbox"/>
4	<input type="checkbox"/>	<input type="checkbox"/>
5	<input type="checkbox"/>	<input type="checkbox"/>

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES



DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
			CLUSTER	
			TMJ	
			MIGRAINE	
			TENSION	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES



DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
			CLUSTER	
			TMJ	
			MIGRAINE	
			TENSION	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END
DURATION	

SEVERITY	SINUS	WEATHER
1	<input type="checkbox"/>	<input type="checkbox"/>
2	<input type="checkbox"/>	<input type="checkbox"/>
3	<input type="checkbox"/>	<input type="checkbox"/>
4	<input type="checkbox"/>	<input type="checkbox"/>
5	<input type="checkbox"/>	<input type="checkbox"/>

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES



DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES



DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES



DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES



DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES



DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
			CLUSTER	
			TMJ	
			MIGRAINE	
			TENSION	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
			CLUSTER	
			TMJ	
			MIGRAINE	
			TENSION	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES



DAY.....

DATE:...../...../.....

START	END
DURATION	

SEVERITY	SINUS	WEATHER
1	CLUSTER	
2	TMJ	
3	MIGRAINE	
4	TENSION	
5		

TRIGGERS					
INSOMNIA		FOOD		ILLNESS	
CAFFEINE		HUNGER		FATIGUE	
ALCOHOL		LIGHTS		ALLERGIES	
STRESS		ODORS		MOTION	
DEHYDRATION		EYESRTRAIN		NOISE	
WEATHER		PMS			

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP
LOW	LOW	POOR
MED	MED	AVG
HIGH	HIGH	GOOD

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY..... DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES

DAY.....

DATE:...../...../.....

START	END	SEVERITY	SINUS	WEATHER
DURATION		1	<input type="checkbox"/>	<input type="checkbox"/>
		2	<input type="checkbox"/>	<input type="checkbox"/>
		3	<input type="checkbox"/>	<input type="checkbox"/>
		4	<input type="checkbox"/>	<input type="checkbox"/>
		5	<input type="checkbox"/>	<input type="checkbox"/>
		CLUSTER	<input type="checkbox"/>	
		TMJ	<input type="checkbox"/>	
		MIGRAINE	<input type="checkbox"/>	
		TENSION	<input type="checkbox"/>	

TRIGGERS					
INSOMNIA	<input type="checkbox"/>	FOOD	<input type="checkbox"/>	ILLNESS	<input type="checkbox"/>
CAFFEINE	<input type="checkbox"/>	HUNGER	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>
ALCOHOL	<input type="checkbox"/>	LIGHTS	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>
STRESS	<input type="checkbox"/>	ODORS	<input type="checkbox"/>	MOTION	<input type="checkbox"/>
DEHYDRATION	<input type="checkbox"/>	EYESRTRAIN	<input type="checkbox"/>	NOISE	<input type="checkbox"/>
WEATHER	<input type="checkbox"/>	PMS	<input type="checkbox"/>		

ENERGY LEVEL	ACTIVITY LEVEL	SLEEP			
LOW	<input type="checkbox"/>	LOW	<input type="checkbox"/>	POOR	<input type="checkbox"/>
MED	<input type="checkbox"/>	MED	<input type="checkbox"/>	AVG	<input type="checkbox"/>
HIGH	<input type="checkbox"/>	HIGH	<input type="checkbox"/>	GOOD	<input type="checkbox"/>

MEDICATIONS & SUPPLEMENTS

MANE	DOSAGE	TIME	SIDE EFFECTS/COMMENTS

FOOD INTAKE

TIME	FOOD	WATER

NOTES