Medication and Non-Medication Intake Form

Please highlight or circle medications you have tried. Please indicate if they worked (W), didn't work (DW) or if there were any side effects (SE).

Name:____ **D.O.B.** ____________________

Over the Counter

Acetaminophen (Tylenol)
Aleve
Anacin
Aspirin
Excedrin Migraine
Excedrin Tension
Ibuprofen (Motrin, Advil)
Benadryl

Herbal/Vitamin

Migrelief
Feverfew
Migravent
Vitamin D
Petadolex (butterbur)
Magnesium
Vitamin B2
Turmeric
Cannabis

Prescription Pain

Fioricet/ Esgic (Butalbital/Acetaminophen/Caffeine)
Fiorinal (Aspirin/Butalbital/Caffeine)
Fiorinal with Codeine/Fioricet with Codeine
Phrenillin (Butalbital/Acetaminophen)
Naproxen Sodium
Sprix Nasal Spray
Toradol (Ketorolac) Tabs, Injections, IV
Butrans Patch
Demerol (Meperidine)
Dilaudid
Methadone
Morphine IV/IM, MS Contin, Kadian
Nucynta
OxyContin, Xtampza
Percocet (Oxycodone)
Stadol Nasal Spray
Tylenol #3 or #4
Ultram (Tramadol)
Hydrocodone, Vicodin, Norco, Zohydro
Lidoderm Patch
Other ______________________________________

Headache Acute

Imitrex (Sumatriptan) tablets, Nasal Spray & Injections (Sumavel, Zembrace)
Maxalt (Rizatriptan) tablet or MLT (dissolves)
Zomig (Zolmitriptan) or ZMT (dissolves), Nasal Spray
Amerge (Naratriptan)
Axert (Almotriptan)
Frova (Frovatriptan)
Relpax (Eletriptan)
Onzentra Xsail
Reyvow
Treximet
Tosymra NS
Ergomar
Elyxyb
Ubrelvy (Ubrogepant)
Nurtec (Rimegepant)
Midrin
Prodrin
Cambia
Migranal N.S.
DHE IV, IM
Trudhesa

Anti-Inflammatory

Arthrotec (Diclofenac/Misoprostol)
Celebrex (Celecoxib)
Indocin (Indomethacin)
Mobic (Meloxicam)
Voltaren (Diclofenac)
Other ____________________

Blood Pressure

Atenolol (Tenormin)
Bystolic (Nebivolol)
Inderal (Propranolol)
Metoprolol (Lopressor, Toprol XL)
Nadolol (Corgard)
Verapamil (Calan)
Atacand (Candesartan)
Benicar (Olmesartan)
Losartan (Cozaar)
Other ____________________

Anti-Depressant

Desipramine (Norpramin)
Doxepin
Elavil (Amitriptyline)
Pamelor (Nortriptyline)
Vivactil (Protriptyline)
Celexa (Citalopram)
Lexapro(Escitalopram)
Paxil (Paroxetine)
Prozac (Fluoxetine)
Viibryd (Vilazodone)
Zoloft (Sertraline)
Trintellix
Cymbalta (Duloxetine)
Deplin (L-Methylfolate)
Effexor (Venlafaxine)
Fetzima (Levomilnacipan)
Pristiq (Desvenlafaxine)
Remeron (Mirtazapine)
Trazodone (Desyrel)
Wellbutrin (Bupropion)
MAO inhibitors (Emsam, Nardil)
Ketamine
Other______________________

CGRP Prevention

Aimovig Vyepti Ajovy Nurtec Emgality Qulipta

Anti-Seizure

Depakote (Divalproex Sodium)	Keppra (Levitiracetam)	Zonegran (Zonisamide)
Gabapentin, (Gralise) (Horizant)	Trileptal, (Oxcarbazepine) Oxtellar XR	
Gabitril	Topamax (Topiramate) Trokendi XR, Qude:	________________

Mood Stabilizer

Lamictal (Lamotrigine)	Rexulti (Brexpiprazole)	Seroquel (Quetiapine), XR
Lithium (Eskalith, Lithobid)	Saphris (Asenapine)	Zyprexa (Olanzapine)
Caplyta (Lunateperone)	Trileptal (Oxcarbazepine) Oxtellar XR	Vraylar (Cariprazine)
Risperdal (Risperidone)		

Muscle Relaxant

Baclofen	Norflex (Orphenadrine)	Skelaxin (Metaxalone)
Flexeril (Cyclobenzaprine)	Parafon Forte (Chlorzoxazone)	Soma (Carisoprodol)
	Robaxin (Methocarbamol)	Zanaflex (Tizanidine)

Anti Nausea

Compazine (Prochloperazine)	Reglan (Metoclopramide)	Zofran (Ondansetron)
Phenergan (Promethazine)	Tigan (Trimethobenzamide)	Vistaril (Hydroxyzine)
Thorazine (Chlorpromazine)	Ginger	

Anxiety

Ativan (Lorazepam)	Valium (Diazepam)	Xanax (Alprazolam)
Buspar (Buspirone)	Klonopin (Clonazepam)	Other ______________________
Vistaril (Hydroxyzine)		

Corticosteroids

Decadron	Medrol	Prednisone

Other Medications or Treatment

Botulinum Toxin (Botox)	Nerve Block	SPG Block
Low-Dose Naltrexone (LDN)	Cannabis	Namenda

ADD/ADHD

Adderall	Adderall XR	Vyvanse	Mydayis	Focalin	Focalin XR	Intuniv
Ritalin	Ritalin LA	Concerta	Journay PM	Strattera	Other______	

Fibromyaligia

Lyrica	Savella	Cymbalta

Sleep

Ambien	Belsomra	Lunesta	Rozerem	Silenor
Quvivig	Dayvigo	Melatonin	Trazodone	Other____

Fatigue

Nuvigil (Armodafanil)	Provigil (Modafanil)	Sunosi

GI

Miralax	Imodium	Amitiza	Linzess	Trulance	Symproic	Movantik	Viberzi	Librax	Bentyl	Levsin

Non-Medication

Physical Therapy	Biofeedback/Neurofeedback
Psychotherapy	Massage
Meditation	Devices: Gamma Core, Nerivio, STMs mini, Cefaly, Relivion
Acupuncture	

Emergency Room:

What medications worked in the emergency room? What medications didn't work in the emergency room?

Headache Intake Assessment Form

Name: ____ Date: __________

Date of Birth ______________ Age: _________ Gender: Male___ Female___ Other_____

Marital Status:________ Name of Significant Other:______________________________

Education: ____

Occupation: ______________________ Significant Other's Occupation: ____________

Name(s) and Age(s) of Children: ____

____

Pets: ____

How old were you when you started having headaches? ______________________________

Does anyone in your family have a history of headaches or migraines? If yes, please specify__________

____

How often do you have a mild-moderate headache? ____________________________

How often do you have a severe headache/migraine? __________________________

How long do the severe headaches last? ____ hour(s) ____ one day ____ two days ____ three or more days

On a scale of one to ten, with ten being the worst, how severe are the headaches?

1 2 3 4 5 6 7 8 9 10

Mild Moderate Severe

Do you have some type of headache every day? ________________________________

How much do these daily headaches bother you? Mildly _____ Moderately _____ Severely _______

Where does the pain occur for your mild-moderate headaches? ______________________

____

Where does the pain occur for your severe headaches/migraines? ____________________

____

What does your headache typically feel like? (please circle one)

Throbbing/pulsing *Pressing/squeezing* *Sharp/stabbing* *Dull/achy*

Does your eye tear on the side of the headache?	Yes	No	
Are the headaches much worse in the last few months?	Yes	No	
Are the headaches much worse in the last year?	Yes	No	
Do you have nausea with your migraines?	Yes	No	
Do you typically have visual problems with your headaches such as flashing lights, sprinkles of light or vision loss on one side?	Yes	No	
Do you experience sensitivity to light?	Yes	No	
Do you experience sensitivity to sound?	Yes	No	
Are your headaches worse before or during your menstrual cycle?	Yes	No	N/A
Do you take any birth control pill or hormone?	Yes	No	N/A

Circle the following if you think these play a role in your headache or migraine:

Stress	Exercise
After stress is over	Exertion
Weather changes	Missing a meal
Foods:	Cigarette odor
Bright sunlight	Perfume odors
Sexual Activity	Season Changes:
Under sleeping	Summer
Oversleeping	Fall
Hormonal changes	Winter
Menstrual cycle	Spring

Have you had any of the following tests? If so, please bring the most recent copy of results with you.

CT of Head? Yes or No If so, date? ____________________ Results ____

MRI of Head? Yes or No If so, date? ____________________ Results ____

Date of last blood test ______________________________ Were they normal? ____

Which family doctors or other doctors do you see?____

____

____

____

Which doctors have you seen for headaches, if any? ____

____

____

Other Medical History:

Do you have very cold feet and hands in winter? Yes No

Do you get motion sickness? Yes No

Do you smoke cigarettes? Yes No If yes, how many per day?_______

Do you drink alcohol? Never Occasionally Daily

Have you had any type of drug/alcohol addiction in the past? ____

How often do you exercise and what types do you do? ____

How much liquid do you drink per day? ____

How many mg of caffeine do you consume per day? ______________________________

Do you have Anxiety? Yes No

If yes, is your anxiety mild, moderate or severe? ______________________________

Do you have a history of Depression? Yes No

If yes, when was your last episode? __________ Is/was it: Mild Moderate or Severe

Do you have trouble Sleeping? Yes No

If yes, do you have trouble going to sleep and or staying asleep? ____________________

How many hours of sleep do you get per night? ______________________________

Concussion or Head Injury? ______________________________

A.D.H.D.? ______________________________

Stomach Ulcers or Stomach Problems? ______________________________

Irritable Bowel Syndrome? __________ Constipation ________ Diarrhea __________

Thyroid? ______________________________

Cholesterol? ______________________________

Hypertension? ______________________________

Diabetes? ______________________________

Asthma? ______________________________

Past Operations? ______________________________

Any other medical conditions?

____

____

____

What prescription medications or over-the-counter medications/supplements are you **currently** taking?

What is the **dose**? (List all medications for all medical conditions)

____

____

____

____

____

____

Side effects or allergies to any past medications? ______________________________

____

____

____

Stress Intake Form

Robbins Headache Clinic

Name:______________________________________ Date:________________

How did you hear abut the practice? ____

If referred, name and phone number of referring physician: ______________________________

___

Family History: briefly describe age, any medical problems and personality traits.

Father:
____

Mother: ____

Siblings:____

____

____

List several traits that best describe YOUR personality:
____

____

____

____

History of clinical/counseling therapy? Yes or No

If yes, was it *Inpatient* or *Outpatient* (circle one) Dates: ______________ Currently ongoing?: Yes or No

Primary therapist was/is: (circle one) Psychiatrist Marriage Counselor Psychologist Social Worker

Primary reason for seeing the above: ____

____

____

____

(Turn page over)

Current areas in which I am under stress include: (circle all that apply)

Work	Marriage
School	Financial Pressure
Time Management	Relationship with Family
Relationship with Children	None of the above

Please elaborate briefly on any items checked above: ____________________

____

____

Please note if any of the following apply to you and briefly elaborate:

History of alcoholism or drug addiction in family? ____________________

____

Emotional or physical abuse as a child? ____________________

____

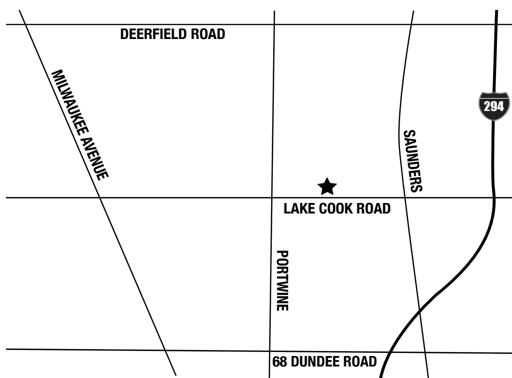
Suicidal thoughts past or present? ____________________

____

Are family and/or friends supportive of your health conditions?____________________

____

____



Robbins Headache Clinic
2610 Lake Cook Road, Suite 160
Riverwoods, IL 60015

Directions to Robbins Headache Clinic

Located on the North side of Lake Cook Road in the "**Global Sourcing Connection**" building, about 1/2 mile West of I-294 and about 1 mile East of Milwaukee Ave., next to the **Holiday Inn Express**.

www.RobbinsHeadacheClinic.com
Office: (847)-374-9399

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name:____ Date:__________

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Instructions: Please circle the number that corresponds with your feelings.

	Not at all	Several days	More than half the days	Nearly every day
1. Little Interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself, or that you are a failure, or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly, that other people could have noticed. Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself.	0	1	2	3

Total Score:

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