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

Herbal/Vitamin

Migrelief
Vitamin D
Vitamin B2
Feverfew
Petadolex (butterbur)
Turmeric
Migravent
Magnesium
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)
Gabapentin, (Gralise) (Horizant)
Gabitril
Keppra (Levitiracetam)
Trileptal, (Oxcarbazepine) Oxtellar XR
Topamax (Topiramate) Trokendi XR, Qudexy
Zonegran (Zonisamide)
Other ________________

Mood Stabilizer

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

Muscle Relaxant

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

Anti Nausea

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

Anxiety

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

Corticosteroids

Decadron
Medrol
Prednisone

Other Medications or Treatment

Botulinum Toxin (Botox)
Low-Dose Naltrexone (LDN)
Nerve Block
Cannabis
SPG Block
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
Psychotherapy
Meditation
Acupuncture
Biofeedback/Neurofeedback
Massage
Devices: Gamma Core, Nerivio, STMs mini, Cefaly, Relivion

Emergency Room:

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

Neurological 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:____

What problem have you come in for today? ________________________________

____

When did this problem start?____

Please state everything that you would like to tell the provider about this problem:________________

____

____

____

____

____

____

____

____

____

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

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 doctors have you seen for this condition, if any?____________________________

____

Which family doctors or other doctors do you see?________________________________

____

____

____

<u>Other Medical History:</u>

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 <u>Anxiety</u>? Yes No

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

Do you have a history of <u>Depression</u>? Yes No

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

Do you have trouble <u>Sleeping</u>? 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? ______________________________________

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 **<u>currently</u>** taking?

What is the **<u>dose</u>**? (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: ____

____

____

____

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

Work

School

Time Management

Relationship with Children

Marriage

Financial Pressure

Relationship with Family

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? ______________________________

____

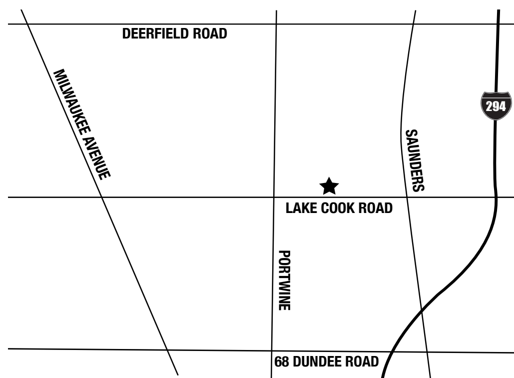
Suicidal thoughts past or present? ______________________________

____

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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