Medication and Non-Medication Intake Form Rev. 3-25

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

Headache Acute

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

Anti-Inflammatory

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

Blood Pressure

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

Anti-Depressant

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

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

Fibromyaligia

Lyrica
Savella
Cymbalta

Sleep

Ambien
Quvivig
Belsomra
Dayvigo
Lunesta
Melatonin
Rozerem
Trazodone
Silenor
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?

Headache Intake Assessment Form Rev. 3-25

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

Rev. 3-25

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: _____

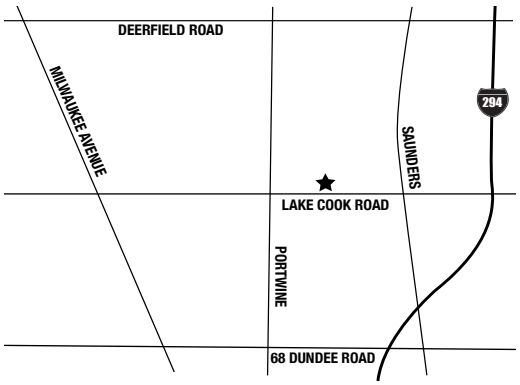
Please note if any of the following apply to you and briefly elaborate:

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 two-story building across the parking lot from the **Holiday Inn Express**. Our office is about 1/2 mile West of I-294 and about 1 mile East of Milwaukee Ave.

PATIENT HEALTH QUESTIONNAIRE (PHQ-9) Rev. 3-25

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: