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) | Keppra (Levitiracetam) | Zonegran (Zonisamide)
Gabapentin, (Gralise) (Horizant) | Trileptal, (Oxcarbazepine) Oxtellar XR
Gabitril | Topamax (Topiramate) Trokendi XR, Qudexy | Other _____

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?

Neurological 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:_____

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:_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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

_____

Which family doctors or other doctors do you see?_____

_____

_____

_____

Other Medical History: Rev. 3-25

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? _____

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

Rev. 3-25

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

Please elaborate briefly on any items checked above: _____

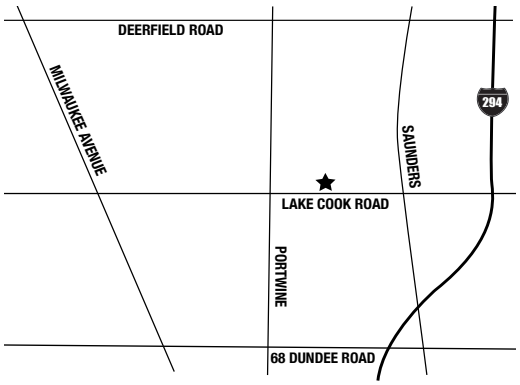
Please note if any of the following apply to you and briefly elaborate:

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.

www.RobbinsHeadacheClinic.com

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: