Headache Intake Assessment Form

Name: ___________________________________________ Date: ______________________

Age: ________ Sex:  M  F  Marital Status _________________________________________

Name of Spouse: ________________________________________________________________

Name(s) and Age(s) of children: __________________________________________________

Name(s) & Types of Pets: _________________________________________________________

Education: ___________________________________________________________________

Occupation: __________________________ Spouse’s occupation: ______________________

Does anyone in your family have headaches, or have they had moderate-to-severe headaches in the past? ________________________________

How old were you when you started having headaches? ___________________________________________________________________

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? __hours __one day __ two days __three or more days

On a scale of one to ten, 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 daily headaches? ___________________________________________________________________

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

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

<table>
<thead>
<tr>
<th>Throbbing/pulsing</th>
<th>Pressing/squeezing</th>
<th>sharp/stabbing</th>
<th>dull/achy</th>
</tr>
</thead>
</table>

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 frequently have nausea with your headaches? 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 typically experience sensitivity to light? Yes  No

Do you typically experience sensitivity to sound? Yes  No

Are your headaches worse before or during your menstrual cycle? Yes  No

Do you take any birth control pill or hormone? ______________________________________
Circle the following if these play a role in your headaches or in producing an occasional headache:

- 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
different seasons:
- summer
- fall
- winter
- spring

Do you have very cold feet and hands in the winter? ____________________________________________

Have you had any of the following tests?
CT scan for your headaches? Y or N If so, when? __________ Results ______________
MRI for the headaches? Y or N If so, when? __________ Results ______________
Blood tests in the past year? ________________ Were they normal? ________________

Have you tried Biofeedback or relaxation training for headaches? Yes No
If yes, has it helped? ____________________________________________
____________________________________________________________________________

How much do you exercise, and what do you do? ____________________________________________
____________________________________________________________________________

Which doctors have you seen for headaches, if any? ____________________________________________
____________________________________________________________________________
____________________________________________________________________________

Which family doctors or other doctors do you see? ____________________________________________
____________________________________________________________________________
____________________________________________________________________________
Do you smoke cigarettes?  Yes  No  If yes, how many______________________________
Do you drink alcohol?  Never  Occasionally  Daily
Have you had any type of problem with addictive drugs in the past? ______________________
Do you tend to be anxious or nervous?  Yes  No
If yes, is your anxiety mild, moderate, or Severe? ______________________
Do you have trouble Sleeping?  Y  N  If yes, do you have trouble going to sleep? Or staying asleep? ______________________
Do you have a history of depression?  Y  N  If yes, when was your last episode? ____________
Is/was it:  Mild  Moderate  or Severe

Other past medical history:
Operations? ________________________________________________________________
______________________________________________________________
Ulcers or stomach problems? __________________________________________________
Asthma? ________________________________________________________________
Any other medical problems? __________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________
Side effects or allergies to any medications? ______________________________________________
What medications are you currently taking? ______________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________
STRESS FORM
Robbins Headache Clinic

Name: ________________________________________________________________ Date: ____________________

How did you hear about the practice? ________________________________________________

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

________________________________________________________________________________

Do you have any siblings? Names and ages (if applicable)
________________________________________________________________________________

________________________________________________________________________________

Describe briefly (personality traits, medical problems, etc.):

Father: ________________________________________________________________________

Mother: _______________________________________________________________________

List several traits which best describe your personality: ________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

History of clinical/counseling intervention:   Yes   No

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

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

Other (Please describe) __________________________________________________________

Primary reason for seeing the above: ______________________________________________

________________________________________________________________________________

________________________________________________________________________________

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

Work                                                  Marriage                    Relationship/Interactions w/ parents
School            Financial Pressure                        Relationship/ Interactions w/ children
Time Management                        other (please list below)     none of the above

Please elaborate briefly on any items checked above: __________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

Please note if any of the following apply to you: you may elaborate briefly on any that apply

History of alcoholism in family __________________________________________________________
__________________________________________________________________________________________
Emotional abuse as a child ______________________________________________________________
__________________________________________________________________________________________
Physical abuse as a child ______________________________________________________________
__________________________________________________________________________________________
Early or recent head injury ___________________________________________________________
__________________________________________________________________________________________
Suicidal thoughts (past or present) ____________________________________________________
__________________________________________________________________________________________
Friends and family members do not understand or appreciate the nature of your headaches:
__________________________________________________________________________________________
__________________________________________________________________________________________

Robbins Headache Clinic
Lawrence Robbins, MD
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60 Revere Drive, Suite 330
Northbrook, IL 60062
(847) 480-9399
www.chicagoheadacheclinic.com

Our office is located south of Lake Cook Road on Revere Drive in Northbrook. Revere is one stoplight west of Skokie Boulevard and two stoplights east of Northbrook Court Shopping Center.

Visit us at www.chicagoheadacheclinic.com
# PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>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</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead or of hurting yourself in some way</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

**For office coding**

\[ 0 + \quad + \quad + \quad = \text{Total Score: } \quad \]

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

<table>
<thead>
<tr>
<th>Difficulty Level</th>
<th>Not at all</th>
<th>Somewhat difficult</th>
<th>Very difficult</th>
<th>Extremely difficult</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
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</table>

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MEDICATION HISTORY FORM

Please highlight or circle medications you have tried, and if they worked or any side effects.

**Over the Counter**
- Aspirin
- Aleve
- Excedrin Migraine
- Ibuprofen (Motrin, Advil, etc.)

**Herbal**
- Feverfew
- Vitamin B2 (riboflavin)
- Petadolex (butternut)
- Magnesium Oxide

**Prescription Pain Medications**
- Naproxen Sodium (Anaprox, Naprelan, Naprosyn)
- Fioricet (Butalbital, Acetaminophen, Caffeine)
- Fiorinal (Aspirin/Butalbital/Caffeine)
- Fiorinal/Fioricet with Codeine/Fiorinal #3
- Esgic Plus (Acetaminophen/Butalbital/Caffeine)
- Esgic (Acetaminophen/Butalbital/Caffeine)
- Phrenilin (Butalbital/Acetaminophen)
- Percocet, Percodan, Tylo (Oxycodone)
- Vicodin, Vicoprofen, Lorcat (Hydrocodone)
- Morphine IV/IM MS Contin, Kadian, Avinza
- Panlor Acetaminophen/Caffeine/Dihydrocodeine
- Ultram (Tramadol) Ultracet
- Lidoderm Patch
- Butrans
- Methadone (Dolophine)
- Norgesic, Norgesic Forte, Norflex
- Tylenol #3 or #4
- Fentora
- Oxycontin
- Toradol (Ketorolac) Tabs, injections
- Spix Nasal Spray
- Stadol Nasal Spray
- Demerol (Meperidine)

**Headache Medications**
- Treximet
- Imitrex (Sumatriptan) tablets, Nasal Spray & Injections
- Maxalt (Rizatriptan) tablet or MLT (dissolves)
- Axert (Almotriptan)
- Amerge (Naratriptan)
- Zomig (Zolmitriptan) or ZMT (dissolves), Nasal Spray
- Relpax
- Frova
- Sumavel Dose Pro
- Ergomar SL
- Cafergot Tab, supp., Cafergot PB supp.
- Midrin (isomethep/dichloralphen/acet.)
- Prodrin
- DHE IV, IM
- Cambia
- Migranal Nasal Spray
- Alsumar

**Anti Inflammatory**
- Voltaren (Diclofenac sodium)
- Arthrotec
- Any other anti inflammatories
- Celebrex (Celecoxib)
- Mobic (Meloxicam)
- Indocin (Indomethacin)

**Blood Pressure**
- Inderal (Propranolol)
- Metoprolol (Lopressor, Toprol XL)
- Nadolol (Corgard)
- Atenolol (Tenormin)
- Bystolic
- Verapamil (Calan, Covera HS)
- Cozaar, Hyzaar
- Benicar
- Losartan
<table>
<thead>
<tr>
<th><strong>Anti-Depessant Medications</strong></th>
<th></th>
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<tbody>
<tr>
<td>Vivactil (Protriptyline)</td>
<td>Prozac (Fluoxetine)</td>
</tr>
<tr>
<td>Elavil ( Amitriptyline)</td>
<td>Wellbutrin (Buproprion)</td>
</tr>
<tr>
<td>Pameler (Nortriptyline, Aventyl)</td>
<td>Viibryd</td>
</tr>
<tr>
<td>Doxepin (Sinequan)</td>
<td>Zoloft (Sertalone)</td>
</tr>
<tr>
<td>Desipramine (Norpramin)</td>
<td>Cymbalta</td>
</tr>
<tr>
<td>Lexapro (Escitalopran)</td>
<td></td>
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<thead>
<tr>
<th><strong>Anti-Seizure Medications</strong></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Topamax (Topiramate)</td>
<td>Depakote</td>
</tr>
<tr>
<td>Zonegran</td>
<td>Gabitril</td>
</tr>
<tr>
<td>Trileptal (Oxcarbamezaapine)</td>
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<thead>
<tr>
<th><strong>Mood Stabilizer</strong></th>
<th></th>
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<tbody>
<tr>
<td>Lithium (Eskalith, Lithobid)</td>
<td>Lamictal (Lamotrigine)</td>
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<tr>
<td>Saphris</td>
<td>Abilify</td>
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<thead>
<tr>
<th><strong>Muscle Relaxers Medications</strong></th>
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<tbody>
<tr>
<td>Skelaxin (Metaxalone)</td>
<td>Flexeril (Cyclobenzaprine)</td>
</tr>
<tr>
<td>Zanaflex (Tizanidine)</td>
<td>Parafon Forte (Chloroxazone)</td>
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<thead>
<tr>
<th><strong>Anti Nausea Medications</strong></th>
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<tbody>
<tr>
<td>Compazine (Prochloperazine)</td>
<td>Phenergan (Promethazide)</td>
</tr>
<tr>
<td>Reglan (Metoclopramide)</td>
<td>Tigan (Trimethobamidine)</td>
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<tr>
<th><strong>Anxiety</strong></th>
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<tbody>
<tr>
<td>Xanax (Alprazolam)</td>
<td>Ativan (Lorazepam)</td>
</tr>
<tr>
<td>Diazepam (Valium)</td>
<td>Klonopin (Clonazepam)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Corticosteroids</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medrol</td>
<td>Prednisone</td>
</tr>
</tbody>
</table>

**Other Medications of Treatment:**

Botulinum Toxin (Botox) Trigger Point Shot

**ADD / ADHD**

|  |
|---|---|
| Dexedrine | Intuniv |
| Vyvanse | Ritalin |
| Adderall | Focalin |
| Adderall XR | Focalin XR |
| Concerta |  |

**Fibromyalgia**

|  |
|---|---|
| Lyrica | Savella |

**Sleep Medications**

|  |
|---|---|
| Ambien | Rozerem |
| Lunesta |  |

**Emergency Room**

What medications worked in the emergency room?

What medications didn’t work in the emergency room?