MEDICATION HISTORY 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).

Over the Counter

Aspirin | Aleve | Excedrin Migraine | Anacin

Acetaminophen (Tylenol) | Aspirin Free Excedrin | Ibuprofen (Motrin, Advil, etc.)

Herbal/Vitamin

Feverfew | Vitamin B2 (riboflavin) | Petadolex (butterbur) | Magnesium Oxide

Deplin | Gliacin

Prescription Pain Medications

Naproxen Sodium (Anaprox, Naprelan, Naprosyn)
Fioricet/ Esgic (Butalbital, Acetaminophen, Caffeine)
Fiorinal (Aspirin/Butalbital/Caffeine)
Fiorinal with Codeine/Fioricet with Codeine/Fiorinal #3
Panlor Acetaminophen/Caffeine/Dihydrocodeine)
Phrenilin (Butalbital/Acetaminophen)
Percocet, Percodan, Tylox (Oxycodone)
OxyContin
Vicodin, Vicoprofen, Lorcet (Hydrocodone), Norco
Zohydro
Morphine IV/IM MS Contin, Avinza
Kadian

Lidoderm Patch
Butrans
Methadone (Dolophine)
Tylenol #3 or #4
Fentora
Demerol (Meperidine)
Toradol (Ketorolac) Tabs, injections
Stadol Nasal Spray
Sprix Nasal Spray
Ultram (Tramadol) /Ultracet
Nucynta

Headache Medications

Imitrex (Sumatriptan) tablets, Nasal Spray & Injections, Patch
Maxalt (Rizatriptan) tablet or MLT (dissolves)
Zomig (Zolmitriptan) or ZMT (dissolves), Nasal Spray

Prodrin (Similernea)
Midrin (isomethep/dichloralphen/acet.)

Axert (Almotriptan) | Treximet

Amerge (Naratriptan) | Relpax | Migranal Nasal Spray | DHE IV, IM

Frova | Alsuma | Ergomar SL

Sumavel Dose Pro | Cambia | Cafergot Tab, supp., Cafergot PB supp.

Anti Inflammatory

Voltaren (Diclofenac sodium) | Arthrotec | Celebrex (Celecoxib)

Mobic (Meloxicam) | Indocin (Indomethacin) | Zorvolex

Tvorbex

Blood Pressure

Inderal (Propranolol) | Bystolic | Losartan

Metoprolol (Lopressor, Toprol XL) | Nadolol (Corgard) | Benicar

Atenolol (Tenormin) | Verapamil (Calan, Covera HS) | Atacand(Candesartan)

Anti-Depressant Medications

Vivactil (Protriptyline) | Prozac (Fluoxetine) | Pristiq

Elavil (Amitriptyline) | Wellbutrin (Buproprion) | Paxil (Paroxetine)

Pamelor (Nortriptyline, Aventyl) | Viibryd | Remeron (Mirtazapine)

Doxepin (Sinequan) | Zoloft (Sertaline) | Trazodone (Desyrel)

Desipramine (Norpramin) | Cymbalta | Effexor (Veniafaxine)

Celexa | Fetzima | Brintellix | Lexapro (Escitalopran)

Anti-Seizure Medications

Topamax (Topiramate) Trokendi XR
Gabapentin, Gralise(Neurontin)
Zonegran
Gabitril
Keppra
Trileptal (Oxcarbamezaapine)
Depakote
Oxtellar XR

Mood Stabilizer

Lithium (Eskalith, Lithobid)
Lamictal (Lamotrigine)
Seroquel (Quetiapine), XR
Rexulti

Muscle Relaxers Medications

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

Anti Nausea Medications

Compazine (Prochloperazine)
Phenergan (Promethazine)
Zofran (Ondansetron)
Reglan (Metoclopramide
Tigan (Trimethobenzamide)

Anxiety

Xanax (Alprazolam)
Ativan (Lorazepam)
Buspar (Buspirone)
Diazepam (Valium)
Klonopin (Clonazepam)

Corticosteroids

Medrol Prednisone Decadron Solumedrol PO, IV

Other Medications or Treatment:

Botulinum Toxin (Botox) Trigger Point Shot

ADD / ADHD

Dexedrine
Intuniv
Adderall
Adderall XR
Concerta
Vyvanse
Ritalin
Focalin
Focalin XR

Fibromyaligia

Lyrica Savella

Sleep Medications

Ambien Rozerem Lunesta Belsomra Silenor

Miscellaneous

Namenda Low-Dose Naltrexone

Emergency Room

What medications worked in the emergency room?

What medications didn't work in the emergency room?

STRESS FORM

Robbins Headache Clinic

Name: ____ **Date:**___________________________________

How did you hear abut the practice? ____

If referred, name and 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 that 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: ____

____

____

____

(Turn page over)

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

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

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

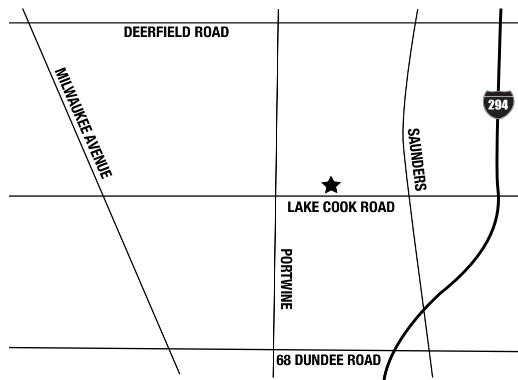
History of alcoholism in family ____

Emotional abuse as a child ____

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
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 "Podolsky Circle" building, about 1/2 mile West of I-294 and about 1 mile East of Milwaukee Ave., next to the Holiday Inn Express.

Our Phone: 847-374-9399

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)*	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 concentration 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 in some way	0	1	2	3
For office coding	__0__	+ _____	+ ______	+ ______

= Total Score: ______

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?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
	☐	☐	☐

Developed by Drs. Robert L Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer, Inc. No permission required to reproduce, translate, display or distribute.

NEUROLOGICAL INTAKE ASSESSMENT FORM

Date: ____

Name: ____

Age:________ Sex: M F Marital Status: ____

Name of Spouse:____

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

____

____

Education: ____

Occupation: _______________________ Spouse's Occupation ________________________

What problem have you come in for today? ______________________________________

____

When did this problem start?____

Please state everything that you would like to tell the doctor about this problem:____________________

____

____

____

____

____

____

____

____

____

____

____

____

____

(turn page over)

Have you had a CAT scan in the past? Y or N If so, when? ____________Results? ______________________

Have you had a MRI in the past? Y or N If so, when? _______________ Results? _______________________

Have you had Blood tests in the past year? _____________ Were they Normal? ________________________

Which doctors have you seen for this problem, if any?____

____

____

Which family doctor or other doctor's do you see? ____

____

____

Do you Smoke Cigarettes? ____

Do you drink Alcohol? Never__________ Occasionally______________ Daily ___________________________

Have you had any type of problems with Addictive Drugs in the past? _______________________________

Do you tend to be Anxious or Nervous? ____

Is the Anxiety Mild______________, Moderate________________ or Severe _________________?

Do you have trouble Sleeping_________, Going to Sleep________, or Staying Asleep __________?

Do you tend to be Depressed? Y or N When was your last episode? _________________________________

Is it Mild_____________, Moderate______________________ or Severe ____________________________

Other past Medical History:

Operations? ____

Neck Pain?____

Ulcers or Stomach problems?____

Asthma? ____

Any other Medical Problems? ____

____

Side effects or Allergies to any medications?____

____

____

What Medications are you currently taking?____

____

____