MEDICATION & NON-MEDICATION HISTORY FORM Rev.9-22-20

Name:________________________________

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

Acetaminophen (Tylenol)
Anacin
Aspirin Free Excedrin
Ibuprofen (Motrin, Advil)
Aleve
Aspirin
Excedrin Migraine

Herbal/Vitamin

Deplin
Gliacin
Migravent
Vitamin B2 (riboflavin)
(Feverfew) MigreLief
Magnesium Oxide
Petadolex (butterbur)
Turmeric

Prescription Pain Medications

Fioricet/ Esgic (Butalbital/Acetaminophen/Caffeine)
Fiorinal (Aspirin/Butalbital/Caffeine)
Fiorinal with Codeine/Fioricet with Codeine/Fiorinal #3
Phrenilin (Butalbital/Acetaminophen)
Naproxen Sodium (Anaprox, Naprelan, Naprosyn)
Sprix Nasal Spray
Toradol (Ketorolac) Tabs, injections, IV
Butrans Patch
Demerol (Meperidine)
Dilaudid

Methadone (Dolophine)
Morphine IV/IM MS Contin, Avinza, Kadian
Nucynta
OxyContin, Xtampza
Percocet, Percodan, (Oxycodone)
Stadol Nasal Spray
Tylenol #3 or #4
Ultram (Tramadol) /Ultracet
Vicodin, Vicoprofen, (Hydrocodone), Norco, Zohydro
Other

Headache Medications

Imitrex (Sumatriptan) tablets, Nasal Spray & Injections (Sumavel, Zembrace)
Ubrelvy (Ubrogepant)
Maxalt (Rizatriptan) tablet or MLT (dissolves)
Midrin (isomethep/dichloralphen/acet.)
Zomig (Zolmitriptan) or ZMT (dissolves), Nasal Spray
Prodrin (isometheptene/caffeine/acet.)

Amerge (Naratriptan)
Axert (Almotriptan)
Frova (frovatriptan)

Onzentra Xsail, Tosymra NS
Relpax (eletriptan)
Treximet
Reyvow
Ergomar

Cambia
Migranal Nasal Spray
DHE IV, IM
Nurtec

Anti Inflammatory

Arthrotec
Celebrex (Celecoxib)
Indocin (Indomethacin)
Mobic (Meloxicam)
Voltaren (Diclofenac sodium)
Other ____________________

Blood Pressure

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

Anti-Depressant Medications

Desipramine (Norpramin)
Doxepin
Elavil (Amitriptyline)
Pamelor (Nortriptyline)
Vivactil (Protriptyline)

Celexa (Citalopram)
Lexapro (Escitalopram)
Paxil (Paroxetine)
Prozac (Fluoxetine)
Viibryd
Zoloft (Sertaline)

Brintellix or Trintellix
Cymbalta (Duloxetine)
Deplin
Effexor (Venlafaxine)
Fetzima
Pristiq (Desvenlafaxine)

Remeron (Mirtazapine)
Trazodone (Desyrel)
Wellbutrin (Bupropion)
MAO inhibitors (Emsam, Nardil)
Other____________________

CGRP

Aimovig
Vyepti
Ajovy
Emgality

Anti-Seizure Medications

Depakote (divalproex sodium)
Gabapentin, Gralise (Neurontin)
Gabitril
Keppra
Trileptal, Oxtellar XR (oxcarbazepine)
Topamax (Topiramate) Trokendi XR, Qudexy
Trileptal (Oxcarbamezaapine)
Zonegran (Zonisamide)
Other ___________________

Mood Stabilizer

Lamictal (Lamotrigine)
Lithium (Eskalith, Lithobid)
Rexulti
Saphris
Abilify (aripiprazole)
Seroquel (Quetiapine), XR
Zyprexa
Vraylar

Muscle Relaxer Medications

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

Anti Nausea Medications

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

Anxiety

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

Corticosteroids

Decadron
Medrol
Prednisone

Other Medications or Treatment

Botulinum Toxin (Botox)
Trigger Point Injection
SPG Block

ADD / ADHD

Adderall
Adderall XR
Concerta
Dexedrine
Focalin
Focalin XR
Intuniv
Ritalin
Vyvanse

Fibromyaligia

Lyrica
Savella

Sleep Medications

Ambien
Belsomra
Lunesta
Rozerem
Silenor
OTC's
Other _____
Melatonin

Miscellaneous

Low-Dose Naltrexone (LDN)
Namenda
Nuvigil
Provigil

GI

Amitiza
Symproic
Movantik
Linzess
Trulance

Outside of Medication - Please Indicate If It Helped(Y) or (N)

Physical Therapy
Psychotherapy
Meditation
Acupuncture
Biofeedback
Massage
Miscellaneous

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 ____

____

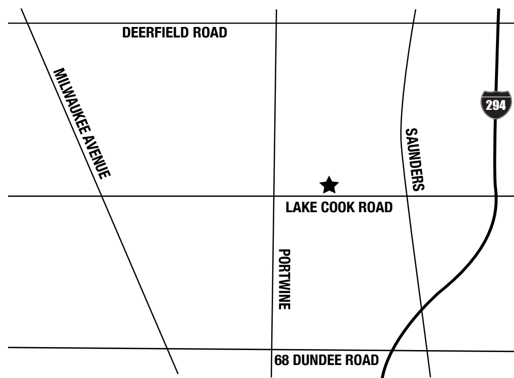
Suicidal thoughts (past or present) ____

____

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 "**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**.

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

Rev. 2/4/20

Name: ____ Date of Birth ____________ Date: _____________________

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? ___________________

Date of last blood test __________ 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? Y or N If yes, how many per day? ____________________________

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? Y or N

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 _______________________

<u>Other past Medical History:</u>

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?

____

____