

Medication and Non-Medication Intake 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).

Name: _____ D.O.B. _____

Over the Counter

Acetaminophen (Tylenol) Aleve	Anacin Aspirin	Excedrin Migraine Excedrin Tension	Ibuprofen (Motrin, Advil) Benadryl
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Herbal/Vitamin

Migrelief Feverfew Migravent	Vitamin D Petadolex (butterbur) Magnesium	Vitamin B2 Turmeric Cannabis
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Prescription Pain

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

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

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

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

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

Aimovig	Vyepti	Ajovy	Nurtec	Emgality	Qulipta
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Anti-Seizure

Depakote (Divalproex Sodium)
Gabapentin, (Gralise) (Horizant)
Gabitril

Keppra (Levetiracetam) Zonegran (Zonisamide)
Trileptal, (Oxcarbazepine) Oxtellar XR
Topamax (Topiramate) Trokendi XR, Qude: _____

Mood Stabilizer

Lamictal (Lamotrigine)
Lithium (Eskalith, Lithobid)
Caplyta (Lunateperone)
Risperdal (Risperidone)

Rexulti (Brexpiprazole) Seroquel (Quetiapine), XR
Saphris (Asenapine) Zyprexa (Olanzapine)
Trileptal (Oxcarbazepine) Oxtellar XR Vraylar (Cariprazine)

Muscle Relaxant

Baclofen
Flexeril (Cyclobenzaprine)

Norflex (Orphenadrine) Skelaxin (Metaxalone)
Parafon Forte (Chlorzoxazone) Soma (Carisoprodol)
Robaxin (Methocarbamol) Zanaflex (Tizanidine)

Anti Nausea

Compazine (Prochlorperazine)
Phenergan (Promethazine)
Thorazine (Chlorpromazine)

Reglan (Metoclopramide) Zofran (Ondansetron)
Tigan (Trimethobenzamide) Vistaril (Hydroxyzine)
Ginger

Anxiety

Ativan (Lorazepam)
Buspar (Buspirone)
Vistaril (Hydroxyzine)

Valium (Diazepam) Xanax (Alprazolam)
Klonopin (Clonazepam) Other _____

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 Journey PM Strattera Other_____

Fibromyalgia

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?

Headache Intake Assessment Form

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? _____

Stress Intake Form

Robbins Headache Clinic

Name: _____ Date: _____

How did you hear about 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: _____

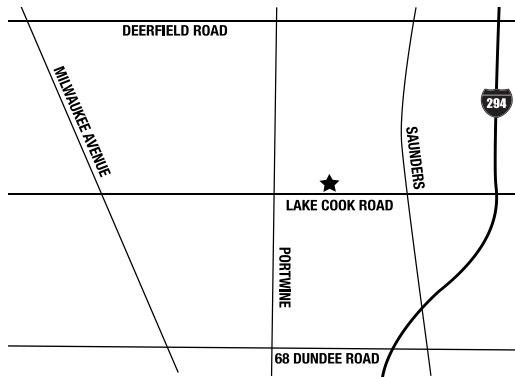
Please note if any of the following apply to you and briefly elaborate:

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 "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**.

Office: (847)-374-9399

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

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: