

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 _____

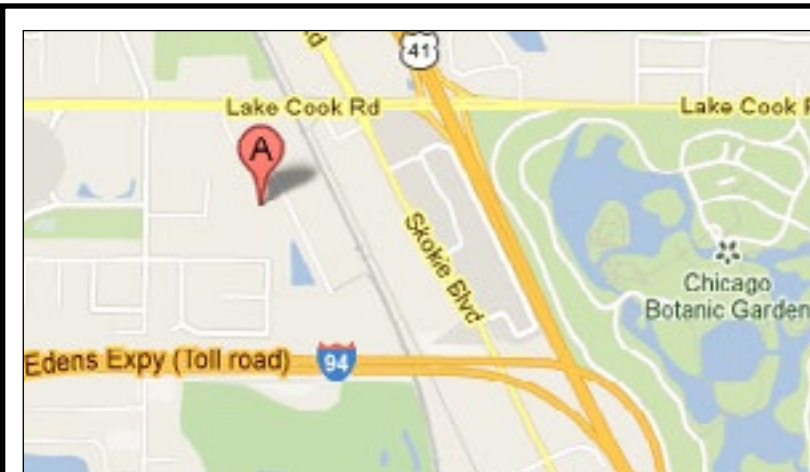
Emotional abuse as a child _____

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

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Visit us at 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.

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 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 in some way	0	1	2	3

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=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

Anti-Depressant Medications

Vivactil (Protriptyline)
Elavil (Amitriptyline)
Pamelor (Nortriptyline, Aventyl)
Doxepin (Sinequan)
Desipramine (Norpramin)
Lexapro (Escitalopran)

Prozac (Fluoxetine)
Wellbutrin (Bupropion)
Viibryd
Zoloft (Sertaline)
Cymbalta

Pristiq
Paxil (Paroxetine)
Remeron (Mirtazapine)
Trazodone (Desyrel)
Effexor (Venlafaxine)

Anti-Seizure Medications

Topamax (Topiramate)
Zonegran
Trileptal (Oxcarbazepine)

Depakote
Gabitril

Neurontin (Gabapentin), Gralise
Keppra

Mood Stabilizer

Lithium (Eskalith, Lithobid)
Saphris

Lamictal (Lamotrigine)
Abilify

Seroquel (Quetiapine), XR
Zyprexa

Muscle Relaxers Medications

Skelaxin (Metaxalone)
Zanaflex (Tizanidine)

Flexeril (Cyclobenzaprine)
Parafon Forte (Chlorzoxazone)

Soma (Carisoprodol)

Anti Nausea Medications

Compazine (Prochlorperazine)
Reglan (Metoclopramide)

Phenergan (Promethazine)
Tigan (Trimethobenzamide)

Zofran (Ondansetron)

Anxiety

Xanax (Alprazolam)
Diazepam (Valium)

Ativan (Lorazepam)
Klonopin (Clonazepam)

Buspar (Buspirone)

Corticosteroids

Medrol Prednisone Decadron Solumedrol PO, IV

Other Medications of Treatment:

Botulinum Toxin (Botox) Trigger Point Shot

ADD / ADHD

Dexedrine Intuniv Adderall Adderall XR Concerta
Vyvanse Ritalin Focalin Focalin XR

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?

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: _____

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? _____
