

MEDICATION & NON-MEDICATION HISTORY FORM Rev. 1-10-22

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) Aleve	Anacin Aspirin	Aspirin Free Excedrin Excedrin Migraine	Ibuprofen (Motrin, Advil)
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Herbal/Vitamin

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

Fioricet/ Esgic (Butalbital/Acetaminophen/Caffeine)	Methadone (Dolophine)
Fiorinal (Aspirin/Butalbital/Caffeine)	Morphine IV/IM MS Contin, Avinza, Kadian
Fiorinal with Codeine/Fioricet with Codeine/Fiorinal #3	Nucynta
Phrenilin (Butalbital/Acetaminophen)	OxyContin, Xtampza
Naproxen Sodium (Anaprox, Naprelan, Naprosyn)	Percocet, Percodan, (Oxycodone)
Sprix Nasal Spray	Stadol Nasal Spray
Toradol (Ketorolac) Tabs, injections, IV	Tylenol #3 or #4
Butrans Patch	Ultram (Tramadol)/Ultracet
Demerol (Meperidine)	Vicodin, Vicoprofen, (Hydrocodone), Norco, Zohydro
Dilaudid	Other

Headache Acute 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)	Onzentra Xsail, Tosymra NS	Cambia	
Axert (Almotriptan)	Relpax (eletriptan)	Migranal Nasal Spray	
Frova (frovatriptan)	Treximet	Ergomar	DHE IV, IM
	Reyvow		Nurtec

Anti Inflammatory

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

Blood Pressure

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

Anti-Depressant Medications

Desipramine (Norpramin)	Celexa (Citalopram)	Brintellix or Trintellix	Remeron (Mirtazapine)
Doxepin	Lexapro (Escitalopram)	Cymbalta (Duloxetine)	Trazodone (Desyrel)
Elavil (Amitriptyline)	Paxil (Paroxetine)	Deplin	Wellbutrin (Bupropion)
Pamelor (Nortriptyline)	Prozac (Fluoxetine)	Effexor (Venlafaxine)	MAO inhibitors (Emsam, Nardil)
Vivactil (Protriptyline)	Viibryd	Fetzima	Other _____
	Zoloft (Sertaline)	Pristiq (Desvenlafaxine)	

CGRP Prevention

Aimovig	Vyepti	Ajovy	Nurtec	Emgality	Qulipta
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Anti-Seizure Medications

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

Mood Stabilizer

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

Muscle Relaxer Medications

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

Anti Nausea Medications

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

Anxiety

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

Corticosteroids

Decadron Medrol Prednisone

Other Medications or Treatment

Botulinum Toxin (Botox) Trigger Point Injection SPG Block

ADD / ADHD

Adderall Concerta Focalin Intuniv Vyvanse
Adderall XR Dexedrine Focalin XR Ritalin

Fibromyalgia

Lyrica Savella

Sleep Medications

Ambien Belsonra 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 Biofeedback
Psychotherapy Massage
Meditation Miscellaneous
Acupuncture

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 about 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

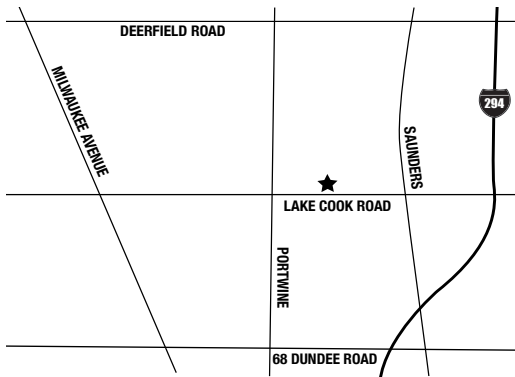
History of alcoholism in family _____

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)	More	Nearly	Several	than half	every
		Not at all	days	the days	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. 1/13/22

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 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? _____

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? _____
