Idaho Joint & Spine, PC

___NEW PATIENT
___INFO CHANGE

DATE:____________________________

PATIENT INFORMATION

(This information is regarding the person who is seeing the doctor)

Patient Name:______________________
Address:______________________
City, State, & Zip:______________________
Date of Birth:__________Age:______Sex:_____
Marital Status:__________Spouse's Name:__________
Social Security Number:______________________
Home Phone:______________________
Cell Phone:______________________
Email:______________________
Reminder Preference (Pick 1): □ Text □ Phone
***By selecting text, you agree that we can send text messages regarding appointments. Please reply "Y" to each message to confirm.**
Preferred Pharmacy:
Employer:______________________
Employer's Phone #:______________________
Primary Care Provider (PCP):______________________
Do you want your records sent to your PCP? □ YES □ NO

Policy Holder Info OR Responsible Party □ MYSELF
(If someone other than patient is responsible for the bill we will need the following)
Relationship to Patient: O Spouse O Parent O Other
Name:______________________
Date of Birth:______________________
Address:______________________
City, State, & Zip:______________________
Home Phone:______________________
Cell Phone:______________________
Employer:______________________
Employer Address:______________________
Social Security Number:______________________

NEAREST RELATIVE INFORMATION
(This information will be used when we are unable to contact the patient.
Name:______________________
Relationship to Patient:______________________
Phone Number:
Referred By:

INSURANCE INFORMATION

Please select one: □ Health Insurance □ Worker's Comp* □ Auto Accident* □ Self
* Is this visit due to: □ Injury on the job? ___/___/___ date of injury □ Automobile accident ___/___/___ date of injury

Primary Insurance: ______________________ Policy Number______________________
Secondary Insurance:______________________ Policy Number______________________

Worker's Comp Insurance Company: ______________________ Claim Number______________________
Worker's Comp Adjuster: ______________________ Phone: ______________________

Liable Insurance Company Name: ______________________ Claim Number______________________
Attorney: ______________________ Phone: ______________________

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the above-named agency to release any treatment information requested by attorneys, physicians, insurance companies, employers, health care providers or any other entity which may be concerned with the payment of charges incurred for the treatment services of Idaho Joint & Spine, PC and hereby authorize payment directly to Idaho Jpint & Spine, PC.
I accept responsibility for payment of any charges not paid for or accepted by my insurance.

__________ ______________________
Date Patient (If not the patient, please indicate legal relationship)

I have reviewed this office's NOTICE OF PRIVACY PRACTICES which explains how my medical information will be used and disclosed. I understand I am entitled to receive a copy of this document.

__________ ______________________
Date Patient (If not the patient, please indicate legal relationship)

Office Use Only: □_______Insurance Cards Copied □_______ID Copied □______Practice Fusion □_______AMD

Idaho Joint and Spine

Dr. James Whitaker, D.O. Physical Medicine and Rehabilitation

9510 W Fairview Ave., Boise, ID 83704 (208) 322-5922 ph (844) 502-7766 fax

FINANCIAL POLICIES

Thank you for choosing to involve us in your healthcare. We are committed to providing you with quality healthcare. Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communication. Thus, this policy is designed to outline our financial policies. Please read it, ask any questions you may have, and sign the bottom of the form. Additional questions can be addressed to our office manager, Sarah, at (208) 322-5922 or info@idahojointandspine.com. If you would like a copy, please let us know.

1. **Missed and Cancelled less than 24-hour appointments.** Appointments which are cancelled with less than 24-hour notification or "No Show" will be subject to a **$40.00 fee**. We understand that situations arise in which you must cancel your appointment. It is requested that **if you must cancel your appointment you provide more than 24-hour notice**. This will enable another person who is waiting for an appointment to be scheduled in that appointment slot. The Cancellation and "No Show" fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment. We understand that unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval. It is our policy that after three (3) "No Show" appointments or cancellations less than 24 hours during a 12-month period then we reserve the right to discharge you from our practice.
2. **Late Arrival.** Your time is valuable. In order to respect your time and that of other patients, we ask that you **arrive 5 minutes early**. If you are more than 5 minutes late, we may not be able to keep your appointment slot and you may have to reschedule. If this happens, you may be subject to the fees. If you are regularly late to appointments then we reserve the right to discharge you from our practice.
3. **Massage Appointments.** Massage Therapy appointments which are cancelled with less than 24-hour notification or "No Show" will be subject to a **$40.00 fee** and fall under #1 above.
4. **Insurance.** We participate in most insurance plans, including Medicare and Medicaid (Idaho). If you are insured by a plan we do not participate with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment is expected in full each visit until we can verify your coverage. Knowing your insurance coverage is your responsibility. We will attempt to assist in verifying benefits and coverage, but this is not a guarantee. Please contact your insurance company with any questions you may have regarding your coverage.
5. **Co-payments, Co-insurances, and Deductibles.** All co-payments, co-insurances, and deductible amounts must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect these amounts from patients can be considered fraud and violate our contracts. Please help us in upholding the law and keeping our insurance contracts by paying your portions at each visit.
6. **Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by your insurance company. You must pay for these services in full at the time of visit.
7. **Proof of insurance.** All patients must complete our patient information before seeing the doctor. We must obtain a copy of your driver's license or valid legal ID and current valid insurance to provide proof of insurance. If you fail to provide us with correct information in a timely manner, you may be responsible for the balance of your claim. If the coverage you provide is not valid, you will be responsible for the balance.
8. **Claims Submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
9. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you. Please be aware that if your insurance company requires a referral to see a specialist and it is your responsibility to ensure that happens.
10. **Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

Please sign that you have read, understand and agree to this Financial Policy.

_______________________________ _______________

Patient Name (Please Print) **Date of birth**

_______________________________ _______________

Signature of Patient or Patient Representative **Date**

Idaho Joint and Spine

Dr. James Whitaker, D.O.
Physical Medicine and Rehabilitation
9510 W Fairview Ave., Boise, ID 83704
(208) 322-5922 ph

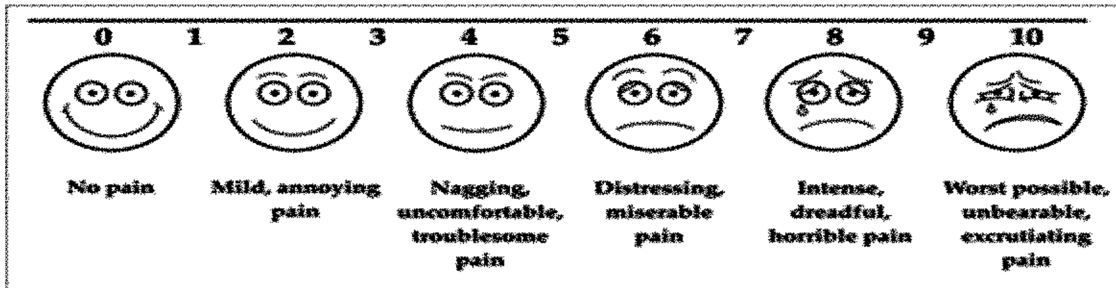
NEW PATIENT QUESTIONNAIRE FOR HEADACHE AND MIGRAINE MANAGMENT

Name: ________________________________

DOB: ____________ **Age:** ______ **Gender:** ____________

CURRENT PHYSICAL STATUS

USING THE PAIN SCALE BELOW, ANSWER THE FOLLOWING QUESTIONS:



How would you rate your pain today? ____________

Over the last five days, what were your pain levels?

Lowest ________ Highest ________ Average ________

Using the symbols below, mark the areas on your body where you feel the described sensation. Include all affected areas.

Aching: Δ Δ Δ Δ

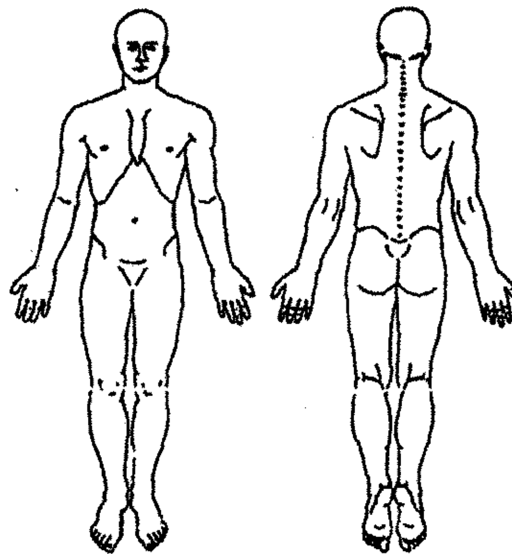
Numbness: ======

Pins & Needles: O O O O O

Burning: X X X

Stabbing: / / / / /

Other: ......



Office Use Only:

BP: _____/_____

HR: __________

Height: _________

Weight: _________

Have you recently had or do you **now** have: ☐ **NONE of the Below**

☐ Fever or Chills	☐ Excessive Fatigue	☐ Weight Gain	☐ Weight Loss
☐ Change in Vision	☐ Eye Pain	☐ Change in Hearing	☐ Ear Pain
☐ Snoring	☐ Nose Bleeds	☐ Difficulty Swallowing	☐ Gum Trouble
☐ Neck Pain	☐ Neck Lumps	☐ Cough	☐ Wheezing
☐ Shortness of Breath	☐ Chest Pain	☐ Palpitations	☐ Abnormal Heartbeat
☐ Swollen Ankles	☐ Nausea	☐ Vomiting	☐ Constipation
☐ Diarrhea	☐ Loss of Bowel Control	☐ Loss of Bladder Control	☐ Difficulty Urinating
☐ Blood in Urine	☐ Hives	☐ Rash	☐ Backache
☐ Muscle Pain	☐ Muscle Weakness	☐ Knee Pain	☐ Shoulder Pain
☐ Headaches	☐ Numbness	☐ Tingling	☐ Lack of Coordination
☐ Recent Falls	☐ Depression	☐ Anxiety	☐ Poor Sleep
☐ Easy Bruising	☐ Large Lymph Nodes	☐ Hair Change/Loss	☐ Increased Appetite

Right Handed? ☐ or Left Handed? ☐

Do you use any of the following? ☐ **NONE of the Below**

☐ Crutches	☐ Cane	☐ Artificial Limb
☐ Walker	☐ Brace/Splint	☐ Wheelchair

☐ Other ______________________________

Do you need assistance with any the following: ☐ **NONE of the Below**

☐ Dressing	☐ Bathing	☐ Caring for hair	☐ Shaving
☐ Yard Work	☐ Eating	☐ Meal Preparation	☐ Using the toilet
☐ Housework	☐ Shopping	☐ Walking	☐ Driving a Car

☐ Other ______________________________

SOCIAL HISTORY

Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

Highest Education Level? ______________________________

Employment: ☐Unemployed ☐ Employed–Part Time ☐ Employed–Full Time ☐ Student ☐ Other

Current or Most Recent Employment (Company, Location, Position, How long?) ______________

____

HEALTH HABITS

Do you use caffeine? ☐ Yes ☐ No If Yes, # beverages per day?______________

Do you consume alcohol? ☐ Yes ☐ No If Yes, how much? ________ How often? ____________

How many days per week do you exercise? ______________________________

What kind of exercise do you typically do? ______________________________

Do you use currently use tobacco? ☐ Yes ☐ No

If Yes, how many packs per day? _________ For how many years? ______________

Have you ever used tobacco? ☐ Yes ☐ No

If Yes, when did you quit? ______________________________

Do you or did you use illicit drugs? ☐ Yes ☐ No

If Yes, what type? ______________ How often or When? ______________

What are your hobbies and interests?______________________________

MEDICAL HISTORY

What medical conditions do you have? (Check all that apply.) ☐ **NONE of the Below**

☐ Head Trauma	☐ Diabetes	☐Hearing Problems	☐ DVT
☐ Heart Attack	☐ COPD	☐ Asthma	☐ GERD
☐ Arthritis	☐ Gout	☐ Psoriasis	☐ Seizures
☐ Stroke	☐ Depression	☐ Thyroid Disease	☐ Vision Problems
☐ Cancer	☐ Fractures	☐ High Blood Pressure	☐ Kidney Problems
☐ Liver Problems	☐ Osteoporosis	☐ Pregnant (Currently)	☐ Previous C-Section
☐ Sleep Apnea	☐ Fibromyalgia	☐ Irritable Bowel	☐Chronic Fatigue Syndrome

☐ **Other:** ______________________________

Do you have any history of abuse? ☐ NO ☐ YES If yes, ☐ Physical ☐ Sexual ☐ Emotional

What surgeries or hospitalizations have you had? ☐ **NONE**

What ______________________ When ______________

What ______________________ When ______________

What ______________________ When ______________

Have you had any previous injuries? ☐ Yes ☐ No

If YES, what was injured and when did it occur? ______________________

What medical problems run in your family? ______________________

____

MEDICAL EXAMS

Date of you last complete physical exam (month and year)? ______________

Physician who performed your last complete exam? ______________

Date of most recent laboratory testing (month and year? ______________

Any abnormal findings in the lab tests? (If yes, please specify) ______________

ALL CURRENT MEDICATIONS ☐ NONE

List all medications you are currently taking. List preventative medications first then abortive/acute medications. Include all over the counter supplements, and vitamins. (Write on back for more room)
The last 2 pages of this form contain a list of common medications for your reference.

Name of Medication	Dosage / Amount		Frequency / How Often?	Date Started	Is the med effective?	Side Effects Experienced

ALL PAST HEADACHE MEDICATIONS ☐ **NONE**

List only medications you are no longer taking. Include all over the counter supplements, and vitamins.
The last 2 pages of this form contain a list of common medications for your reference.

Name of Medication	Dosage / Amount	Frequency / How Often?	Date Started	Date Stopped	Reason for Discontinuation

Are you allergic to any medications? ☐ Yes ☐ No If yes, please list below.

____

Any history of substance abuse? If yes, explain: _______________________________

HEADACHE HISTORY

Please mark the types of headaches you have:

☐ Migraine ☐Tension ☐Sinus ☐ Cluster ☐Menstrual ☐Unknown

How old were you when you first started experiencing headaches of any type? _______

How old were you when you first started experiencing bad headaches? _______

How many days per month do you get headaches of any type? _______

How many days per month do you get bad headaches (interfere with ability to do things? _______

How many days per month do you take medication to relieve your headaches? _______

How painful do your headaches usually get? 1 (almost no pain) to 10 (worst pain imaginable) _______

Number of unscheduled visits to doctor's office for headache treatment in the *past 6 months* _______

Number of visits to the ER or Urgent Care for headache treatment in the *past 6 months* _______

Does anyone else in your family have headaches? ☐ NO ☐ YES If yes, who? _______

HEADACHE TRIGGERS

Please circle the number that represents **how often(0-100%)** each of these triggers your headaches.
0=Never 1=Occasionally (1-33% of the time) 2=Frequently (34-66%) 3=Nearly always (67-100%)

How Often	Trigger	How Often	Trigger	How Often	Trigger
0 1 2 3	Stress	0 1 2 3	Hormones	0 1 2 3	Sleep
0 1 2 3	Let-down Periods	0 1 2 3	Weather	0 1 2 3	Not Eating
0 1 2 3	Neck pain/Stiffness	0 1 2 3	Lights/Glare	0 1 2 3	Caffeine
0 1 2 3	Relationships	0 1 2 3	Perfume/Odors	0 1 2 3	Alcohol
0 1 2 3	Worry/Anxiety	0 1 2 3	Heat	0 1 2 3	MSG
0 1 2 3	Sadness/Depression	0 1 2 3	Smoke	0 1 2 3	Sweeteners
0 1 2 3	Anger/Frustration	0 1 2 3	Travel	0 1 2 3	Other Foods
0 1 2 3	Sexual Activity	0 1 2 3	Altitude	0 1 2 3	Exercise

HEADACHE SYMPTOMS (Please mark symptoms that typically occur just before or during a headache)

☐	H/A lasting longer than 4 hours	☐	Temporary paralysis	☐	Pain when chewing
☐	Pulsating/throbbing pain	☐	Speech problems	☐	Agitation/Restlessness
☐	Pain increased with activity	☐	Difficulty swallowing	☐	Loss of consciousness
☐	One-sided pain	☐	Dizziness	☐	Shortness of breath/chest pains
☐	Moderate to severe pain	☐	Ringing in ears/Ear pain	☐	Flushing/blushing
☐	Light sensitivity	☐	Eyelid/Face	☐	Chills
☐	Sound sensitivity	☐	Eye Irritation and/or tearing	☐	Fever
☐	Nausea and/or vomiting	☐	Drooping runny nose	☐	Excessive sweating
☐	Vision Change Before H/A	☐	Nasal congestion	☐	Hallucinations
☐	Vision Change After H/A begins	☐	Tenderness of scalp	☐	Diarrhea
☐	Face numbness	☐	Tenderness of temples	☐	Constipation
☐	Arm/Leg numbness	☐	Neck/shoulder stiffness	☐	Frequent Urination

Do you have any warning symptoms occurring before (6-48 hrs) the onset of a headache? ☐Yes ☐No

If yes, explain: ____

Any other problems that you think may be causing or intensifying your headaches?________________

____

PREVIOUS TESTS FOR HEADACHE:

Test	**Yes/No**	**Location of Test** (site, city, state)	**Results of Test**	**Year**
Neurological Consult (most recent)	_____	__________________	______________	________
Headache Specialist (most recent)	_____	__________________	______________	________
CT scan of Brain	_____	__________________	______________	________
MRI scan of Brain	_____	__________________	______________	________
MRI or CT scan of Neck	_____	__________________	______________	________
EEG (brain wave tracing)	_____	__________________	______________	________
Sinus x-ray or scan	_____	__________________	______________	________
Spinal Tap	_____	__________________	______________	________
Angiogram (arteriogram)	_____	__________________	______________	________
Transcranial Doppler	_____	__________________	______________	________
EKG (heart)	_____	__________________	______________	________
ENT (ear, nose, & throat) consult	_____	__________________	______________	________
TMJ Specialist	_____	__________________	______________	________
Allergy Testing	_____	__________________	______________	________
Other Testing:______________	_____	__________________	______________	________

PREVIOUS TREATMENTS FOR HEADACHE

(Please note different kinds of treatments you have tried for your headaches)

Treatment	Yes/No	Who treated you? (Name of Dr, Location)	Treatments Effective?	Year(s)
Acupuncture	______	______________________	____________________	_________
Chiropractics	______	______________________	____________________	_________
Osteopathic Manipulation	______	______________________	____________________	_________
Biofeedback/Relaxation Therapy	______	______________________	____________________	_________
Psychotherapy/Counseling	______	______________________	____________________	_________
Physical Therapy	______	______________________	____________________	_________
Nutritional Therapy	______	______________________	____________________	_________
Trigger Point Injections	______	______________________	____________________	_________
Nerve Blocks	______	______________________	____________________	_________
In-Patient Hospitalization (For Headaches)	______	______________________	____________________	_________
Other Treatments:__________	______	______________________	____________________	_________

HEADACHE IMPACT TEST – 6

	Never	Rarely	Some Times	Very Often	Always
When you have headaches, how often is the pain severe?					
How often do headaches limit your ability to do usual daily activities including household work, work, school, or social activities?					
When you have a headache, how often do you wish you could lie down?					
In the past 4 weeks, how often have you felt too tired to work or do daily activities because of your headaches?					
In the past 4 weeks, how often have you felt fed up or irritated because of your headaches?					
In the past 4 weeks, how often did headaches limit your ability to concentrate on work or daily activities?					
	6 pts each	8 pts each	10 pts each	11 pts each	13 pts each
Total Scores:					

For Office Use Only	Total Score: __________

HOW HEADACHES IMPACT YOUR LIFE – MIDAS

Please answer the following questions about *ALL your headaches* you have had over the last 3 months. Write the *number of days* on the line next to each question. Write "0" if you did not do the activity in the last 3 months.

1. How many days in the last 3 months did you miss work or school because of headaches? _______ days
2. How many days in the last 3 months was your productivity at work or school reduced by half or more because of your headaches? (**Do not include days you counted in question 1**). _______ days
3. How many days in the last 3 months did you not do household work because of headaches? _______ days
4. How many days in the last 3 months was your productivity in household work reduced by half or more because of your headaches? (**Do not include days you counted in question 3**). _______ days
5. How many days in the last 3 months did you miss family/social/leisure activities because of headaches? _______ days

For Office Use Only	Total Score: __________

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Please mark only one answer)*	Not at All (0 points)	Several Days (1 point)	More Than Half the Days (2 points)	Nearly Every Day (3 points)
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				
Trouble falling or staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself — or that you are a failure or have let yourself or your family down				
Trouble concentrating on things, such as reading the newspaper or watching television				
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				
Thoughts that you would be better off dead or of hurting yourself in some way				
Column Totals:				

For Office Use Only	**Total Score: __________**

	Not at All (0 points)	Several Days (1 point)	More Than Half the Days (2 points)	Nearly Every Day (3 points)
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?				

GENERALIZED ANXIETY DISORDER 7-ITEM (GAD-7) SCALE

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Please mark only one answer)*	Not at All (0 points)	Several Days (1 point)	More Than Half the Days (2 points)	Nearly Every Day (3 points)
1. Feeling nervous, anxious, or on the edge				
2. Not being able to stop or control worrying				
3. Worrying too much about different things				
4. Trouble relaxing				
5. Being so restless that it's hard to sit still				
6. Becoming easily annoyed or irritable				
7. Feeling afraid as if something awful might happen				
Column Totals:				

For Office Use Only	**Total Score: __________**

	Not at All (0 points)	Several Days (1 point)	More Than Half the Days (2 points)	Nearly Every Day (3 points)
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?				

AMOUNT OF SLEEP

On work/school days I usually go to bed at	________	am/pm	On my days off I usually go to bed at	________	am/pm
On work/school days I usually get up at	________	am/pm	On my days off I usually get up at	________	am/pm
On work/school days I usually sleep	________	hours	On my days off I usually sleep	________	hours

EPSWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? *This refers to your usual way of life in recent times. (Even if you have not done some of these things recently, try to work out how they would have affected you.) Use the following scale to choose the most appropriate number for each situation:*

	Would Never Doze (0 pt)	Slight Chance of Dozing (1 pt)	Moderate Chance of Dozing (2 pt)	High Chance of Dozing (3 pt)
1. Sitting and Reading	______	______	______	______
2. Watching TV	______	______	______	______
3. Sitting inactive in a public place	______	______	______	______
4. As a passenger in a car for an hour without a break (e.g., theatre)	______	______	______	______
5. Lying down to rest in the afternoon (when circumstances permit)	______	______	______	______
6. Sitting and talking with someone	______	______	______	______
7. Sitting quietly after lunch without alcohol	______	______	______	______
8. In a car, while stopped for a few minutes in traffic	______	______	______	______

For Office Use Only	Total Score: __________

THOUGHTS/COMMENTS YOU FEEL ARE IMPORTANT REGARDING YOUR HEADACHES:

**** I attest that this information is true and accurate to the best of my knowledge.***

PATIENT SIGNATURE____ **DATE** ____________

DOCTOR SIGNATURE____ **DATE** ____________

(The last two pages of this form are for reference only to fill out the medications portion.)

Medication List to Help With Your History

Blood Pressure Medicines

Beta Blockers

Atenolol	Tenormin
Labetalol	Trandate
Metoprolol	Lopressor, Toprol
Nadolol	Corgard
Propranolol	Inderal, InnoPran
Timolol	Blocadren

Calcium Channel Blockers

Amlodipine	Norvasc
Diltiazem	Cardizem
Flunarizine	Sibelium
Nicardipine	Cardene
Nifedipine	Procardia, Adalat
Nimodipine	Nimotop
Verapamil	Calan, Isoptin

ACE-inhibitors

Captopril	Capoten
Enalapril	Vasotec
Lisinopril	Zestril, Prinivil
Quinapril	Accupril
Trandolapril	Tarka
Benzapril	Lotensin

ARBs

Candasartan	Atacand
Irbesartan	Avapro
Olmosartan	Benicar
Losartan	Cozaar
Telmisartan	Micardis

Alpha-adrenergic inhibitors

Clonidine	Catapres
Doxazosin	Cardura

Diuretics

Acetazolamide	Diamox
Furosemide	Lasix
Hydrochlorothiazide	
Triamterene/HCTZ	Dyazide

Antidepressants

Tricyclics

Amitriptyline	Elavil
Nortriptyline	Pamelor
Desipramine	Norpramin
Imipramine	Tofranil
Protriptyline	Vivactil
Doxepin	Sinequan
Clomipramine	Anafranil

SSRI's

Citalopram	Celexa
Escitalopram	Lexapro
Fluoxetine	Prozac
Paroxetine	Paxil
Sertraline	Zoloft

SNRI's

Duloxetine	Cymbalta
Venlafaxine	Effexor, Pristiq
Milnacipan	Savella

Atypical antidepressants

Bupropion	Wellbutrin
Trazodone	Deseryl
Mirtazapine	Remeron
Nefazodone	Serzone

Other psych meds

Clozapine	Clozaril
Ziprasidone	Geodon
Risperidone	Resperdal
Quetiapine	Seroquel
Olanzapine	Zyprexa
Aripipazole	Abilify

MAO inhibitors

Isocarboxazid	Marplan
Phenelzine	Nardil
Tranylcypromine	Parnate

Anti-Anxiety

Alprazolam	Xanax
Oxazepam	Serax
Lorazepam	Ativan
Clonazepam	Klonopin
Diazepam	Valium
Clorazepate	Tranxene
Buspirone	Buspar

Sleeping Aids

Zolpidem	Ambien
Ramelteon	Remeron
Zaleplon	Sonata
Eszopiclone	Lunesta
Hydoxyzine	Atarax, Vistaril
Ramelteon	Rozerem

COX-2 Inhibitors

Celecoxib	Celebrex
Rofecoxib	Vioxx
Valdecoxib	Bextra

NSAIDs

Aspirin	
Diclofenac	Voltaren
Difunisal	Dolobid
Etodolac	Lodine
Fenoprofen	Nalfon
Flurbiprofen	Ansaid
Ibuprofen	Advil, Motrin

Indomethacin	Indocin
Ketoprofen	Orudis
Ketoralac	Toradol
Meclofenamate	Meclomen
Nabumetone	Relafen
Naproxen	Aleve, Anaprox
Oxaprozin	Daypro
Piroxicam	Feldene
Sulindac	Cliniorll
Meloxicam	Mobic

Anti-Seizure / Anti-Convulsant

Carbamazepine	Tegretol
Clonazepam	Klonopin
Phenytoin	Dilantin
Divalproex	Depakote
Gabapentin	Neurontin
Topiramate	Topamax
Zonesimide	Zonegran
Levetiracetam	Keppra
Lamotrigine	Lamictal
Tiagabine	Gabatril
Pregabalin	Lyrica
Oxcarbazepine	Trileptal

Stimulant / Anti-Manic

Dextroamphetamine	Dexedrine
Methylphenidate	Ritalin, Concerta
Amphetamine	Adderall
Permoline	Cylert
Atomoxetine	Strattera
Lithium	Lithobid. Eskalith

Triptans

Almotriptan	Axert
Eletriptan	Relpax
Frovatriptan	Frova
Naratriptan	Amerge
Rizatriptan	Maxalt
Sumatriptan	Imitrex
Zolmitriptan	Zomig

Ergots

Bromocriptine	Parlodel
Dihydroergotamine	DHE-45, Migranal NS
Ergonovine	Ergotrate
Ergotamine	Cafergot
Methylergonovine	Methergine
Methysergide	Sansert

Phenobarb/Belladona	Bellergal

Muscle Relaxants

Baclofen	Lioresal
Carisprodol	Soma
Cyclobenzaprine	Flexeril
Methocarbamol	Robaxin
Orphenadrine	Norflex, Norgesic
Tizanidine	Zanaflex
Metaxalone	Skelexin

Narcotic / Opioid Analgesics

Butorphanol	Stadol NS
Fentanyl	Duragesic, Actiq
Fioricet/Fiorinal with Codeine	
Oxycodone	Percocet, Tylox
Hydrocodone	Lortab, Vicodin
Codeine	Tylenol #3
Oxycontin	
Morphine	
Tramadol	Ultram, Ultracet
Meperidine	Demerol
Hydromorphone	Dilaudid
Propoxyphene	Darvocet
Methadone	

Analgesics

Butalbital/Aspirin	Fiorinal
Butalbital/Tylenol	Fioricet, Esgic
Aspirin/Acetaminophen/Caffeine (Excedrin)	
Lidocaine	Lidoderm patch
Lidocaine	nasal spray
Isometheptane	Midrin

Anti-Ulcer

Lansoprazole	Prevacid
Omeprazole	Prilosec
Pantoprazole	Protonix
Esomeprazole	Nexium
Rebeprazole	Aciphex
Ranitidine	Zantac

Anti-Nausea

Metoclopramide	Reglan
Prochlorperazine	Compazine
Promethazine	Phenergan
Odansetron	Zofran
Trimethobenzamide	Tigan
Granisetron	Kytril