The Royal College of
**Chiropractors**

# Headache

## Chiropractic Assessment and Management Flowchart

Patient Presenting with **Headache**

Take a **Patient History**
Including detailed headache-specific inquiries
**(See Box 1)**

Consider completion of:
- **Headache Questionnaire** (eg HIT-6)
- **Headache Diary**

Perform a **Physical Examination**
- Neurological assessment (including cranial nerves)
- Measurement of blood pressure
- Palpation of temporal arteries
- Head and neck examination
- Fundoscopy (if experienced and competent)

Consider **Red Flags (see Box 2)**

**POSITIVE Red Flags** may require urgent **Referral**, and/or further inquiry or investigation (as appropriate)

Identify **Headache Type(s) (see Box 3)**

Headaches **NOT** matching the clinical features of Migraine, Tension Type or Cervicogenic Headache - consider referral and/or further inquiry or investigations (as appropriate)

Headaches matching the clinical features of **Migraine, Tension Type or Cervicogenic Headache** (noting that they may co-exist):
- Provide patient explanation, education and reassurance
- Give information on the risk of Medication-Overuse Headache
- Make decision whether to manage, co-manage or refer (in full consultation with the patient)

Make **Referral** (as appropriate)

Select Individualised **Management Options** considering headache type (through shared decision-making with the patient) considering:
- Manual Therapies (inc. manipulation, mobilisation and soft tissue therapies)
- Exercise Prescription (inc. strengthening, stretching and aerobic)
- Physical activity and lifestyle advice
- Cognitive behavioural interventions
- Acupuncture / myofascial dry needling
- Biofeedback techniques

**Interprofessional Communication**
- Correspond with GP and/or other managing HCPs

Carry out regular **Reviews** (initially within 4 weeks)
- Use outcome measures (eg HIT-6)
- Review patient headache diaries
- Consider additional referrals or co-management with other HCPs

**Evidence Guide**

Not all interventions are equally effective for all headache conditions.

- **Spinal manipulation** appears better indicated for cervicogenic and migraine headaches, and a multimodal approach best for tension type headache.
- **Exercises** to re-educate deep neck flexors may be beneficial in cervicogenic and tension type headaches. Aerobic exercise may be effective for migraine and tension type headaches.
- **Acupuncture** may be considered for chronic tension-type headaches and migraines.

## Box 1: Headache Patient History Guide

These headache-specific criteria of a patient history should be addressed in addition to all the normal elements of a standard medical history, including the assessment of psychosocial factors, past medical history and family history.

### Context /Past History 1

- past headache history
- recent change in headache pattern or type (assess different headache types separately)
- co-existing medical conditions / medications

### Timing 2

- time since onset of presenting headaches
- cause of initial onset / precipitating event
- onset and duration of each headache
- frequency and temporal pattern (eg. episodic, intermittent, daily, constant)

### Location and Character 3

- location (site & spread)
- intensity (VAS)
- pain type (nature & quality)
- aura symptoms (visual or sensory)
- associated symptoms*

### Influencing Factors 4

- predisposing factors and / or trigger factors
- aggravating factors
- relieving factors
- family history of similar headaches

**Patient History**

### Response 5

- behaviour during a headache
- effective interventions / medications
- self-management strategies

### Impact/Psychosocial 6

- state of health between headaches
- effects on ability to function normally
- impact on work (eg days off work)
- impact on family / social life / relationships
- concerns, beliefs, anxieties and fears

### Management 7

- past / current healthcare professionals
- investigations carried out
- preventative strategies
- current headache medications
- previously tried medications

*Associated symptoms may include nausea, vomiting, dizziness, photophobia, blind spots, flashing lights, upset stomach, light headed, noise sensitivity, eye tearing, drooping or swollen eyelid, eye pain, rhinorrhoea, nasal congestion, tinnitus, insomnia, fever, neck stiffness, weakness, visual disturbances, restlessness, numbness, paraesthesia, muscle stiffness and tenderness.



## Box 2: Headache Guide to Red Flags

**Headache Red Flags** are signs, symptoms, or aspects of a patient's history that raise the suspicion of a secondary pathological cause for headache rather than the existence of a primary headache such as migraine or tension type. Although their presence does not guarantee pathology, positive red flags warrant further enquiry, investigation, or referral, and a degree of caution in proceeding with care.

### All Patients with Headache A

**Recent Head Trauma** (usually within 3 months)
**Thunderclap** - rapid progression to peak headache intensity (< 5 minutes)
Headache described as **"The Worst Headache Ever"**

**Abnormal Neurological Findings** (on examination)
**Focal Neurological Symptoms** (eg. motor weakness, aura < 5 minutes or > 1 hour)
**Non-Focal Neurological Symptoms** (eg. cognitive or personality changes, seizure)

**Jaw Claudication** with/without **Visual Disturbance**

Headache that **Changes with Posture**
Headache that **Wakes Patient from Sleep** (if a new headache)
Headache that **Worsens over Weeks**

Headache **Precipitated by Physical Exertion or Valsalva Manoeuvre** (eg. coughing, laughing, straining)

**New** & **Severe** Headache with **Systemic Illness** (eg. fever, neck stiffness, muscle pain, vomiting, cold feet, rash)
**New**, **Severe** & **Unilateral Occipital** Headache (esp. younger people, recent infection or minor neck trauma)

### Patients with known Headache History B

**Change** in Headache **Frequency**, **Characteristics** or **Associated Symptoms**

**Worst / Severe** Headache with **Systemic illness** (eg. fever, neck stiffness, muscle pain, vomiting, cold feet, rash)

### Specific Patient Groups: C

| | |
|---|---|
| **Over 50 Years** | New onset or change in headache |
| **HIV Infection** | New onset or change in headache |
| **History of Cancer** | New onset or change in headache |
| **Pregnancy / Post-Partum** | New onset or change in headache |
| **Combined Oral Contraceptive** | First time Aura |

## Box 3: Headache Differential Diagnosis Guide

Headache diagnosis is reliant on a thorough patient history to establish a typical clinical picture. However, it is common for patients to present with mixed or multiple headaches, which can make diagnosis a clinical challenge. The most common headaches, and those most likely to present to chiropractors, are the 2 main primary headaches (tension type headache and migraine), medication-overuse headache and cervicogenic headache. These, together with cluster headache, should all be considered once a serious secondary headache has been excluded.

| **Based on:** ICHD 3rd Edition Classification | **Primary Headache** | | | **Secondary Headache** | |
|---|---|---|---|---|---|
| | **Migraine Headache** | **Tension Type Headache** (TTH) | **Cluster * Headache** | **Cervicogenic Headache** | **Medication-Oveuse Headache (MOH)** |
| **Frequency** | From one to several a month | Variable but often daily or most days | From once every other day to 8 times a day | Daily | 15 or more days in a month |
| **Severity** | Moderate to Severe (NRS: 6-10/10) | Mild to Moderate (NRS: 4-6/10) | Severe to Very Severe (NRS: 10/10) | Mild to Severe (NRS: 4-9/10) | Mild to Severe (NRS: 2-10/10) |
| **Location** | Unilateral or Alternating Unilateral | Bilateral / Around Head | Unilateral | Posterior (Back to front) / Unilateral | Generalised / Bilateral |
| **Nature of Pain** | Throbbing / Pulsating | Pressing / Tight / Gripping / Band-like | Stabbing / Sharp | Ache Radiating from Occipital Area into Head, Neck and/or Face | Diffuse / Pressure |
| **Visual Aura** | +/– | – | +/– | – | +/– |
| **Duration** | 4-72 Hours | Variable / Often Constant | 15-180 Minutes | Hours / Constant | Hours / Constant |
| **Nausea** | ++ | +/– | +/– | +/– | – |
| **Photophobia / Phonophobia** | ++ | +/– either/or (but not both) | + | – | – |
| **Vomiting** | + | – | +/– | – | – |
| **Activity** | Need to rest & keep still, and normal activity aggravates | Can act normally, but can reduce desire to exercise | Restless, pacing, cannot stay in bed | Worse with neck movement, and often first thing in morning | Normal |
| **Examination** | Normal, with possibility of some occipital and trapezius tenderness | Often muscle referral patterns | Cranial autonomic features during headaches | Pain on neck movement, and clinical signs of neck dysfunction | Normal |
| **Neck Stiffness** | +/– | +/– | – | + | – |
| **Quantity / Temporal Characteristics** | **Chronic** if > 15 days/ month of headaches, of which 8 are migraine, for >3 months<br>If not, **Episodic** | **Chronic** if headaches occur on ≥15 days/month on average, for >3 months<br>If not, **Episodic** | At least 5 episodes | *(consider TTH or mixed headache if more myofascial than cervical)* | Regular use for >3 months of one or more drugs taken for acute or symptomatic treatment of headache |
| **Note: It is very common for people to present with mixed or multiple headaches** | | | | | |

*Cluster Headache is the most common form of the **Trigeminal Autonomic Cephalalgias** (TACs). Although rare, the three other forms are Paroxysmal Hemicrania, Short-Lasting Unilateral Neuralgiform, and Hemicrania Continua. These headaches typically occur multiple times daily, lasting anything from a few seconds to 30 minutes, are unilateral in the trigeminal distribution (often around the eye), and are moderate to severe in intensity. All forms of TAC should be referred for assessment and management.