Hey there,

Congratulations on getting hold of '*Become a therapist who can consistently solve chronic headaches – 10 steps.'*

Now I can tell you from experience that if you can get lasting outcomes for patients with headaches, then you will get busy. Simple. Why? Because headaches are the 3rd most common disabling condition affecting the world's population, and very few therapists are providing lasting answers.

I am personally frustrated by the number of patients that waste so much time and money on treatment without lasting results I have decided to pass on some GOLD advice that will help YOU become a therapist who can consistently solve chronic headaches. And when I say solve, I mean 'solve'. That is: getting a lasting (don't need to see you again) kind of solution.

I have decided to cut through the crap and simplify the process. Using a clear process of elimination, asking the right questions and paying attention to detail will empower you as a thinking therapist to solve the majority of chronic headache presentations and make your patients raving fans.

Now it must be said that a simple problem-solving framework does not mean headaches are not complex. Let me say from the outset, the truth is…there is no magic. No silver bullet. Headaches are complicated. But these steps will give you more clarity with a treatment framework that can lead you through the maze to get great results consistently.

Regards,

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Here is your 10 Step guide:

Become a therapist who can consistently solve chronic headaches.

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1. First – You must differentiate between true neurovascular migraines[1] and 'the rest'.

Headaches today are categorized as vascular migraines, tension headaches, cluster headaches, ice pick headaches, myofascial headaches, – blamed on stress, diet, under exercise, over exercise, posture, hormones, food intolerances, Cervicogenic, TMJ, and the list goes on. You can simplify this by dividing all headaches into 2 groups.

True neurovascular migraines and…

…the rest.

The biggest differences between true neurovascular migraines and 'the rest' is that NV Migraines will:

- have aura (funny visual disturbances – dots, lines, loss of vision etc)
- will often lead to nausea AND vomiting.
- Relief comes with a dark room, no exercise and cold on the head.

2. Make distinguishing the difference easy for your patient.

So, keep it simple. Ask your patient. 'Do you get visual disturbances?' 'Do your headaches lead to vomiting?' and 'How do you get relief?'

These questions are really useful but must be asked specifically as stated because 'the rest' of the headache categories can cause nausea but NOT vomiting, can cause blurred vision but NOT dots, lines, loss of vision and finally 'the rest' of the headache categories respond well to heat, exercise and movement.

So don't confuse yourself or your patients with the ridiculous amount of headache terminology out there. Start by figuring out which of the 2 main types of headache your patient is presenting with.

[1] Migraines have traditionally been considered primarily vascular. Vasoconstriction and sudden vasodilation of the intracranial blood vessels causing throbbing pressure and pain. Recent research has described a neuro component making 'neurovascular' a more accurate name for this presentation.

1. Steiner TJ, Stovner LJ, Birbeck GL. Migraine: the seventh disabler. *J Headache Pain*. 2013;14(1):1. doi: 10.1186/1129-14-1
2. Amin FM, Asghar MS, Hougaard A, et al. Magnetic resonance angiography of intracranial and extracranial arteries in patients with spontaneous migraine without aura: a cross-sectional study. *Lancet Neurol.* 2013;12(5):454-461.
3. Jacobs B, Dussor G. Neurovascular contributions to migraine: moving beyond vasodilation. *Neuroscience*. 2016;338:130-144.

3. Know that 'the rest' are almost entirely myofascial head pain arising from the neck or jaw. So work the probabilities.

Suspect that 15% of chronic headache presentations have a true NV Migraine element.
Suspect that 80% of head pain is referred from structures in the neck.
Suspect that 20% of head pain has is arising masticatory muscles and TMJ.[2]
Suspect that a very small percentage of headaches are 'other.'[3]

If you are any good at maths you will notice that the % here don't add up. And this is because most patients suffering with true NV Migraine are suffering from overlapping pain from neck and / or jaw as well. [4]

When I say 'work the probabilities,' I mean get good at identifying and treating that 80% group. That is; pain arising from structures in the neck. Truth be told, in my experience, the baffling list of 'different' types of headache (tension, cluster, ice pick, myofascial, Cervicogenic etc etc) will all respond famously to good treatment of the cervical structures and jaw. In other words, it is not just the 'Cervicogenic' headaches that are 'Cervicogenic'!

4. Study all of the muscles that Travell and Simons Myofascial Trigger Point Manuals[5] describe as referring to the head.

Without going into lots of detail here, let me just say that I am aware of all the questions around the pathophysiology of trigger points and the way advocates of current pain science will argue that trigger points and even manual therapy itself is out of date and irrelevant.

I love the current pain science and think it actually compliments so many of Travells clinical observations. All I will say here is that this paper is not for that fight – and – if you just want to help people and get amazing clinical results KNOW Travells' jaw and Cervical skeletal muscle referred pain patterns. Non-negotiable.

And here is how to apply that knowledge…

5. Ask lots of question and take good notes - be specific in pain presentation, ask, ask and ask again.

If you have asked the questions in steps 1 and 2 and decided that your patient is NOT getting NV Migraines then first:

Ask lots of questions about the **location of the pain.** Consider Travells' myofascial pain locations and consider the muscles that may be referring to those locations.

And second:
Get your patient to demonstrate a full active **range of movement** in the neck, rotation, flexion, extension and side flexions and ask them if they have any pain OR stiffness in neck movement.

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[2] In order to determine jaw involvement, ask your patient if they have localised TMJ pain, clicking or locking of the jaw, tooth or jaw pain or ear pain.
[3] Note that constant unabating 24/7 pain is a red flag. Refer to a GP.
[4] These percentages are estimates based on the thousands of cases I have seen clinically, they are not a reflection of any particular research papers.
[5] Click on these links to see the books or charts - Travell and Simons Trigger point manuals, Travell and Simons Trigger point wall charts

6. Your goal over 3-6 sessions is to restore full pain free, stiffness free movement to the neck and jaw.

Let me give you some tips to succeed in this:

a. Take really good notes. In follow up treatments you must be able to describe to your patient the symptoms they presented with in the previous treatment and then help them to distinguish changes in the pain pattern.
b. Understand that it is just as important to get the neck 'stiffness free' as it is to get the neck 'pain free.' If there is stiffness in the neck on ROM then the job isn't finished.
c. Understand that most people with chronic headaches have multiple overlapping referred pain patterns so over a course of treatment the pain will appear to change location more than once. Repeat step 5.

7. What do to with your hands or dry needles!

I use hands gentle cross fibre hands on manipulation to the trigger point locations for about 10 - 20 seconds at a time on average. In order to do this well:

a. Be good with your surface anatomy and know what you have got your hands on.
b. Be specific - Understand that the secret to successful manipulation is not the pressure or the duration but the **specificity** of your work.
c. Don't kill your patient with your hands-on work. Understand that any hands-on intervention is ultimately introducing a stimulus anticipating a response from the brain. Hands on interventions are NOT 'loosening the muscle directly' per sae, so go easy.
d. Superficial dry needling in these locations will be effective as well.
e. Follow this link to see how I manipulate trigger point locations.
f. Join a KingMyoPro training group – 60+ videos, tutorials and case studies over 7 weeks to master your knowledge of these pain patterns, hands-on assessment and treatment.

8. Treat these certain areas every treatment.

A massive percentage of chronic headaches arise from sternocleidomastoid, upper Splenius Cervicis and the Sub Occipital muscles. Even if you believe that your patients pain patterns are arising from different muscles, treat these muscles every treatment. Why? Because if they ARE contributing to the headaches and you treat other areas but not these muscles, then these muscles WILL give your patient a headache the next day.

9. Compliment the treatment with a cervical neutral posture for 10 minutes per day.

Have a look at this link and observe the lady lying on the posture pole. This posture is really effective for any cervical dysfunction. It is very effective on a flat surface like the floor, it does not have to be on a posture pole.

Attention to detail is important. Note that the head is in a neutral position. Which for most people means they will need to tuck the chin a little once lying and the Cervical lordosis under the neck

should be present. Prescribe 10 minutes, 2x per day for the duration of the treatments that you are performing. Amazingly simple, amazingly effective.

10. What to do with the 15% of patients with true neurovascular migraines.

a. First, if your patient IS presenting with NV Migraine symptoms then perform steps 1 – 9 and eliminate any overlapping headaches from the Cervical and Jaw.
b. Second, be aware that often this course of treatment for the Cervical will reduce or resolve the NV Migraines even though technically they are not arising from the neck.
c. Know that NV Migraines have a 'systemic' trigger. Identifying those triggers is a big step in the right direction. Hormonal? Food? Stress? Are the most common. Get good at educating your patients around the systemic triggers for vascular migraines.
d. Often once you can clear all the 'other' headaches, the NV Migraines are much more obvious and identifying the trigger becomes easier.
e. In a small percentage of cases the only solution is management of those triggers. So be prepared to refer to a naturopath to do a food elimination diet or a GP for hormonal control considerations or vasoconstriction medications.