



HEADACHES: NOT ALL IN YOUR HEAD



Headaches: Not All in Your Head

A practical guide to identifying drivers, tracking triggers, and charting a headache-free future.

A patient guide from

Rejuv Headache Institute

Rejuv Medical | Waite Park & Edina, Minnesota

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This guide is educational and does not replace medical advice. If you have emergency symptoms, seek urgent care.

Quick Start

If you're overwhelmed and just want a starting point, begin here:

- Track your headache days for the next 14 days (a simple template is included).
- Write down every medication/supplement you've tried (and whether it helped).
- Gather past imaging reports and specialist notes (MRI/CT reports are especially helpful).
- Note any neck symptoms: stiffness, reduced range of motion, "crunching," or pain into the shoulder/upper back.
- If you're ready for a comprehensive evaluation, schedule a Headache & Neck Assessment with our team.

Why this matters

Headaches are common, but the reasons they persist are often missed.

A structured evaluation + good data (your history, patterns, prior treatments) helps us make faster, more accurate decisions.

What you'll get from this guide

- A clearer explanation for why headaches can keep returning—even after normal imaging and multiple medications.
- A simple framework to understand common "drivers" of persistent headaches (and what to do about them).
- A checklist to prepare for your visit so we can maximize your first appointment.
- An overview of what a comprehensive headache evaluation looks like—so you know we'll take a true differential diagnosis approach, not guess.

Headache disorders are extremely common worldwide, and migraine is one of the leading causes of disability (GBD 2016 Headache Collaborators, 2018; Steiner et al., 2020). Yet many people are still underdiagnosed or undertreated (World Health Organization, 2025).

If you've tried "everything," this is probably familiar

You've tried multiple medications.

Your imaging was "normal" (or showed changes that didn't explain the pain).

You've seen different providers, and each one had a different theory.

You might have been told: "It's stress," "It's just migraine," or "You'll have to live with it."

If that's you: you're not weak, and you're not imagining it.

Persistent headaches usually mean that one or more underlying drivers are still active—or the nervous system has become sensitized.

What makes the Rejuv Headache Institute different

We built our program around one idea: headaches are often multi-factorial—so care should be, too. Our goal is to give you a clear diagnosis, reduce headache days, and build a plan that lasts.

- A true differential diagnosis approach: we don't assume every headache is "just migraine."
- Safety-first screening for red flags and appropriate imaging/labs when needed (Do et al., 2019; American College of Radiology, 2022).
- Head + neck evaluation (mobility, stability, nerves, posture)—because the neck is often part of the headache circuit (Bogduk, 2004).
- Evidence-based medication strategies (acute and preventive) when appropriate—coordinated with your other physicians.
- Evidence-based nutraceutical/supplement options when appropriate (American Headache Society, 2021).
- Integrated referral partners: physical therapy, functional medicine, IV therapy, and behavioral health/pain psychology.
- Targeted interventional options (nerve blocks, trigger point work, nerve-focused treatments) when indicated.
- Progress tracking so you can see what's working over time (headache days/month, medication days, disability/impact scores).

A simple truth

A headache diagnosis is not the same thing as a headache driver.

Example: "Migraine" is a diagnosis; drivers might include sleep disruption, neck dysfunction, nerve irritation, hormonal shifts, or persistent inflammation.

Many people also have more than one headache type at the same time (for example migraine + tension-type + cervicogenic patterns), which can make treatment feel like trial-and-error.

The 3 most overlooked drivers of persistent headaches

Most long-standing headaches are not caused by a single thing. We often see three major drivers overlap:

1) Inflammation that doesn't fully turn off

Inflammation is part of healing. The problem is when it becomes stuck in the “on” position.

This can increase pain sensitivity and make the brain and nerves more reactive to normal stimuli.

2) Irritated or “trapped” nerves

Nerves around the head and neck can become irritated by tight tissues, poor motion patterns, prior injuries, or inflammation.

When a nerve is irritated, it can refer pain to the scalp, behind the eye, the temple, or the jaw—depending on the nerve involved.

3) Neck and upper back strain, dysfunction, or instability

The upper neck is deeply connected to head pain pathways.

In fact, upper cervical nerves and trigeminal (face/head) nerves converge in the brainstem, which is one reason neck problems can be felt as “head pain” (Bogduk, 2004).

Neck pain and stiffness are very common in people with migraine and other primary headaches (Ashina et al., 2015; Al-Khazali et al., 2022). That doesn't mean your headache is “only” a neck problem—but it often means the neck is part of the pattern.

Driver #1: Inflammation that doesn't fully resolve

Inflammation isn't always "bad." It's how your body repairs tissue and fights infection. But chronic, low-grade inflammation can keep pain pathways active and make headaches more frequent or more intense.

Common contributors to persistent inflammation include:

- Poor or inconsistent sleep
- High stress load (especially when stress is constant, not occasional)
- Hormonal shifts (for example around the menstrual cycle or perimenopause)
- Diet patterns that don't work for your body (high sugar, high ultra-processed foods, frequent alcohol, etc.)
- Dehydration, low electrolytes, or inconsistent fueling
- Poor recovery after illness or injury

What we do about it

We look for the specific "inflammation amplifiers" in your life and physiology, and build a plan that is realistic—not perfect.

In many cases, addressing inflammation is what makes other treatments work better (medications, physical therapy, procedures, and rehabilitation).

For migraine specifically, research has highlighted key neurochemical players involved in attacks—such as CGRP (calcitonin gene-related peptide)—and medications that target CGRP can reduce migraine attacks in many patients (Iyengar et al., 2019; Wattiez et al., 2020).

Driver #2: Irritated nerves (often missed)

Your head, face, and upper neck are wired together. Signals from upper cervical nerves and trigeminal nerves can converge in the brainstem (Bogduk, 1992; Bogduk, 2004). That means irritation in the neck can be “felt” as head pain—and head pain can amplify neck tightness.

Examples of headache patterns with a strong nerve component can include:

- Pain that starts at the base of the skull and travels upward
- Pain behind one eye or deep in the temple
- Scalp tenderness (it hurts to brush hair, wear a hat, or lie on a pillow)
- Sharp, electric, or stabbing pain (even if it’s brief)
- Headaches triggered by sustained positions (computer work, driving, looking down)

Key point

When nerves are part of the pattern, treating “only the pain” often doesn’t hold. A better strategy is to identify what is irritating the nerve and then restore normal movement, gliding, and tissue tolerance.

This is one reason a comprehensive exam often includes not just a neurologic screen, but also a focused evaluation of the neck, upper back, jaw mechanics, and soft tissues.

Driver #3: The neck is often part of the headache circuit

A “normal brain MRI” is reassuring, but it doesn’t evaluate everything that can drive head pain. The head and neck function as one system, and problems in the upper neck can contribute to headaches through shared nerve pathways (Bogduk, 1992; Bogduk, 2004).

This is especially common after:

- Whiplash or car accidents (even if it was years ago)
- Falls or sports injuries
- Long periods of desk work with a forward-head posture
- Jaw clenching or TMJ issues
- Sleep positions that keep the neck rotated or extended

There is a recognized category of headache where the neck is the primary source (called cervicogenic headache), and it has specific diagnostic criteria (International Headache Society, 2018). But even when you do not meet that strict definition, neck dysfunction can still amplify migraine and tension-type headaches.

Signs your neck may be contributing

Headache starts (or is worse) after sitting, driving, computer work, or looking down.

You wake up with headache + neck stiffness.

Turning your head, looking up, or holding one position reliably triggers symptoms.

You notice upper back tightness, shoulder tension, or “knots” that track with headache flares.

When the nervous system becomes sensitized

With repeated headaches, the nervous system can become “on edge.” This is sometimes called sensitization—meaning the pain system reacts faster and louder than it should.

Sensitization can look like:

- Headaches triggered by smaller stressors than before
- Light, sound, smells, or screen time becoming harder to tolerate
- Pain spreading (from one area to multiple areas)
- More “lingering” symptoms after an attack (brain fog, fatigue, neck tightness)

Another common (and fixable) trap is medication-overuse headache. The International Classification of Headache Disorders defines medication-overuse headache as headache on 15 or more days per month in someone with a pre-existing headache disorder, with regular overuse of acute medications for more than 3 months (International Headache Society, 2018).

If sensitization is part of the picture, the goal is to help your nervous system “turn the volume down” while also treating the drivers that keep turning it up. A comprehensive plan may include:

- Education + a clear plan (uncertainty and fear amplify pain).
- Stepwise return to movement (graded activity), not “push through” or “avoid everything.”
- Sleep optimization (often the highest-leverage migraine and pain intervention).
- Behavioral strategies (CBT-based pain coping, stress regulation, biofeedback) to reduce amplification and improve control.
- Medication and procedure choices that fit your pattern—while avoiding dependence on rescue meds.

Important

Do NOT stop prescription medications abruptly without medical guidance.

If you are concerned about medication overuse, bring your medication list to your visit so we can create a safe plan.

Multidisciplinary headache care (combining education, physical therapy/rehabilitation, and appropriate medical care) has been associated with reduced headache burden and reduced risk of medication-overuse patterns (Gaul et al., 2011).

What a comprehensive headache evaluation looks like

A high-quality evaluation should do three things:

- 1) Make sure nothing dangerous is being missed.
- 2) Identify your most likely headache pattern(s).
- 3) Identify what is driving the pattern for you—so treatment is targeted, not random.

This usually includes:

- A detailed history (onset, triggers, location, timing, associated symptoms, menstrual pattern, sleep, stress, nutrition, hydration).
- A careful review of everything you've already tried (medications, physical therapy, chiropractic, injections, supplements, devices, etc.).
- A focused neurologic screen + a targeted head/neck exam (posture, range of motion, muscle trigger points, nerve tenderness, jaw mechanics).
- A "red flag" screen to determine if urgent imaging or emergency evaluation is needed. Many clinicians use the SNNOOP10 red-flag framework for this (Do et al., 2019).
- Review of prior imaging and labs; ordering new tests only when appropriate.

Imaging is sometimes essential—but not always. For example, the American College of Radiology notes that in a typical primary migraine or tension-type headache with a normal neurologic exam, initial imaging is usually not appropriate, while imaging is recommended when red flags are present (American College of Radiology, 2022).

How we tell headache types apart (a simple differential)

Headache is not one diagnosis. Many people have overlapping patterns (for example migraine plus a neck/nerve component). We use internationally recognized headache criteria, combined with a focused head/neck exam, to identify your most likely pattern(s) and drivers (International Headache Society, 2018).

Pattern we consider	What it often looks/feels like	What we do about it
Migraine (episodic or chronic)	Throbbing or pressure headache with light/sound sensitivity, nausea, brain fog; may have aura.	Build an acute + prevention plan; look for triggers and drivers outside the brain too (sleep, neck, nerves, inflammation).
Tension-type / myofascial headache	Band-like pressure; scalp/neck/shoulder tightness; often stress/desk-work related.	Treat muscle and movement drivers (PT, posture, trigger points) + nervous-system calming strategies.
Cervicogenic (neck-referred) headache	Starts in the neck/occiput; worsens with certain neck positions or movement; often one-sided.	Detailed neck exam; consider PT, joint/nerve-targeted options, and stability work (Bogduk, 2004).
Occipital neuralgia / peripheral nerve pain	Sharp, shooting, electric pain from base of skull; tender nerves; may radiate to temple or behind the eye.	Identify irritated nerves; consider nerve-focused treatments (blocks/hydrodissection) + rehab to reduce recurrence.
Cluster / other TACs	Severe one-sided eye/temple pain with tearing, nasal congestion, eyelid droop; attacks are shorter but intense.	Rapid diagnosis and appropriate escalation; coordinate evidence-based options and specialist collaboration when needed (International Headache Society, 2018).
Medication-overuse headache	Headaches become more frequent while using rescue meds often (many days/week).	Create a safe plan to reduce overuse while improving control with prevention strategies (International Headache Society, 2018).
Post-traumatic / concussion-related	After head/neck injury; often includes neck pain, dizziness, light sensitivity, fatigue, sleep disruption.	Combine neck/vestibular rehab, sleep support, and targeted headache strategies—stepwise.
Note	This is educational—your diagnosis depends on your specific history and exam.	Our goal is to match treatment to your pattern and drivers, not to guess.

Diagnostics we may use (only when it helps)

Not everyone needs imaging or extensive testing. We start with high-yield clinical evaluation and add diagnostics only when they meaningfully guide decisions (American College of Radiology, 2022).

- Headache diary and symptom timeline (frequency, severity, triggers, medication days).
- Validated questionnaires (impact/disability, sleep, stress) when helpful.
- Review of prior imaging and labs; we avoid repeating tests that don't change care.
- Focused head/neck exam: neck range of motion, muscle trigger points, nerve tenderness, jaw mechanics, posture.
- Imaging (MRI/CT/cervical imaging) when indicated—especially if red flags are present or the pattern is changing (Do et al., 2019; American College of Radiology, 2022).
- Targeted lab work in select cases (for example thyroid or inflammation markers) when symptoms suggest a systemic contributor.

The P3 Protocol: Prepare • Plant • Proliferate

Most people don't need more random treatments—they need the right sequence. We use the **P3** protocol: **Prepare** (calm + assess), **Plant** (targeted treatment), and **Proliferate** (build resilience so results last). Think: prepare the soil, plant the seed, proliferate the results.

A simple 3-phase plan (the Rejuv approach)

- 1) Prepare: calm the system (reduce inflammation, improve sleep/recovery, quiet irritated tissues).
- 2) Target: use the most appropriate tools for your pattern (medications, rehab, and—when needed—targeted procedures).
- 3) Proliferate: keep your gains (rehab, stability, nervous system reconditioning, and a maintenance plan).

P3 at a glance

Prepare	Plant	Proliferate
Goal: reduce chaos + get clarity • Safety screen • Identify your pattern(s) • Start tracking	Goal: target your top drivers • Evidence-based meds when needed • Targeted procedures when appropriate • Start rehab	Goal: make results last • Build strength + stability • Calm the nervous system • Prevent relapse
Common actions: • Headache diary • Review prior imaging/records • Red-flag screen (SNNOOP10) • Early relief plan	Common actions: • PT plan (mobility/stability) • Nerve blocks / trigger points • IV support in select cases • Nutrition/sleep/stress plan	Common actions: • Progress tracking (days/month) • Gradual exercise progression • Behavioral skills (CBT/biofeedback) • Long-term prevention
Often: first 1–2 visits	Often: first 4–12 weeks	Often: 3–6+ months (varies)

Depending on your pattern, your plan may include:

Your headache team (optional referral partners)

Headaches are often multi-factorial. Depending on what we find in your evaluation, we may coordinate a team-based plan that can include the following services—under one roof when possible.

Team member	How they can help
Headache clinician (MD/DO/APP)	Quarterbacks your plan. We look for neurologic patterns AND common drivers outside the brain—especially neck, nerves, posture, inflammation, and medication patterns.
Physical therapy & rehab	Restores mobility and stability of the neck/upper back, addresses posture/ergonomics, builds strength, and reduces musculoskeletal triggers.
Interventional pain / procedures	Targeted diagnostic or therapeutic treatments such as nerve blocks, trigger point injections, and other image-guided options when appropriate.
Functional medicine / nutrition	Helps identify systemic triggers (sleep, nutrition, inflammation, deficiencies, hormones) and builds a practical plan to reduce overall headache load.

IV / infusion support	Rescue or support infusions in select cases (for example hydration/electrolytes or magnesium support when clinically appropriate).
Behavioral health / pain psychology	Skills to calm the nervous system and reduce sensitization: stress regulation, CBT-based pain coping, biofeedback, and sleep support. This is not “it’s all in your head”—it’s nervous-system training.
Important	Not every patient needs every option. The goal is the smallest, safest plan that creates durable improvement.

Medical optimization

- Acute (rescue) strategies to stop attacks sooner and reduce ER/urgent care visits
- Prevention strategies when headaches are frequent
- Avoiding or reversing medication-overuse patterns when present (International Headache Society, 2018)
- Evidence-based medication and nutraceutical options may be used when appropriate—personalized to your health history and goals (American Headache Society, 2021).

Rehabilitation & movement

- Neck and upper back mobility + stability training
- Posture and ergonomic coaching for work and driving
- Breathing, relaxation, and graded activity strategies

Targeted in-office treatments (when appropriate)

- Focused diagnostic or therapeutic procedures to reduce pain and clarify drivers (examples: occipital nerve blocks, sphenopalatine ganglion blocks, and selected cervical joint/nerve blocks).
- Trigger point treatments for myofascial contributors
- Ultrasound-guided nerve-focused treatments (including hydrodissection) in select cases of nerve irritation.
- Botox® for chronic migraine when indicated.
- Regenerative injections (PRP/prolotherapy) for specific neck soft-tissue or stability-related contributors when appropriate.
- Infusion-based support in select cases (e.g., hydration/electrolytes or magnesium support when clinically appropriate)

Root-cause support

- Nutrition and anti-inflammatory strategies that fit your life
- Functional medicine support when appropriate (nutrition, metabolic/hormonal factors, inflammation, deficiencies).
- Sleep optimization
- Stress physiology support (because stress can be both a trigger and an amplifier)

There is evidence that multidisciplinary care—when done well—can reduce headache burden and support more durable outcomes (Gaul et al., 2011).

What progress really looks like

A realistic goal is not always “zero headaches immediately.” For many people, progress happens in steps—less frequent attacks, lower intensity, fewer medication days, and faster recovery.

We commonly track:

What we track	Why it matters
Headache days per month	This is the clearest measure of whether your plan is working.
Migraine days per month	Many people have mixed patterns; separating them helps target care.
Peak intensity (0–10)	A drop in intensity can be a big quality-of-life win.
Acute-medication days	Helps prevent medication-overuse patterns and shows improved control (International Headache Society, 2018).
Function	Work, exercise, family time, screen tolerance, and sleep quality.
Neck mobility & stability	Improving mechanics can reduce triggers and keep gains (Bogduk, 2004).

A good outcome is freedom + confidence

You understand your pattern.

You have a plan for flares.

Your baseline is better month after month.

Common myths that keep people stuck

These beliefs are common—and they can delay the right care:

Myth	Reality
"My MRI was normal, so nothing is wrong."	Imaging is important for safety, but many headache drivers are functional (nerves, muscles, joints, sensitivity).
"It's just stress."	Stress is a real amplifier, but it's rarely the only driver. A good plan addresses physiology and mechanics too.
"If it's migraine, it has nothing to do with my neck."	Neck pain is common in migraine and can feed into the head-pain network (Ashina et al., 2015; Bogduk, 2004).
"I've tried many medications—so this is hopeless."	Many people need a different strategy: better diagnosis, fewer but smarter trials, and non-medication tools.
"I should push through workouts even if my headaches flare."	Overpushing can amplify sensitization. A graded, strategic plan is usually better.
"More imaging is always the answer."	Imaging is recommended when red flags are present; otherwise it may not change the plan (American College of Radiology, 2022).

When to seek urgent care

Most headaches are not dangerous. But some symptoms require urgent evaluation. The SNNOOPI0 framework is a common red-flag checklist used by clinicians (Do et al., 2019).

Seek urgent care (ER/911) or same-day medical evaluation if you have any of the following:

- A sudden, severe “thunderclap” headache (max intensity within minutes)
- A new headache with fever, stiff neck, rash, confusion, fainting, or severe illness
- New neurologic symptoms (weakness, numbness, trouble speaking, vision loss, severe dizziness)
- New headache after head/neck trauma
- New or worsening headache during pregnancy or postpartum
- New headache after age 50, or a major change in pattern
- Headache with cancer history or immune suppression
- Headache with a painful red eye or new eye symptoms
- Headache that is clearly positional (much worse upright or lying down) or triggered by coughing/strain

If you’re unsure

Err on the side of safety and get evaluated.

This guide is not meant to diagnose emergency conditions.

Prepare for your first visit

This is one of the highest-impact things you can do. When you arrive prepared, we can spend your visit making decisions—not re-collecting history.

☐ 1) Gather your prior records (bring paper copies or upload ahead of time if available)

☐ Imaging reports (MRI/CT/X-ray reports) + the actual images if you have them (CD/portal download).

☐ Prior neurology or pain clinic notes (especially diagnosis and treatment response).

☐ Recent lab work (thyroid, iron/ferritin, vitamin D/B12, inflammatory markers if done).

☐ ER/urgent care visit summaries related to headaches.

☐ 2) Make a complete list of what you've tried (and what happened)

☐ Rescue meds: triptans, NSAIDs, acetaminophen, anti-nausea meds, etc.

☐ Preventive meds: blood pressure meds, antidepressants, anti-seizure meds, CGRP medications, Botox®, etc.

☐ Supplements: magnesium, riboflavin (B2), CoQ10, vitamin D, etc.

☐ Non-medication treatments: physical therapy, chiropractic, massage, acupuncture, mouthguards/TMJ treatment, devices, injections, infusions.

☐ 3) Identify your top 3 goals for care

☐ Example: "Reduce headache days from 20/month to under 8/month."

☐ Example: "Be able to work a full day without needing rescue meds."

☐ Example: "Lift/Run/Train again without triggering symptoms."

Your Headache Snapshot (fill this out)

You can fill this out on paper, in your phone notes, or print this page.

Typical headache location(s):

☐ one side ☐ both sides ☐ back of head ☐ behind eye ☐ temple ☐ face/jaw ☐ other:

Quality of pain:

☐ pressure/tight ☐ throbbing/pulsing ☐ stabbing/electric ☐ burning ☐ other: -----

Associated symptoms (check all that apply):

☐ nausea ☐ vomiting ☐ light sensitivity ☐ sound sensitivity ☐ smell sensitivity ☐
dizziness/vertigo ☐ visual aura ☐ neck pain/stiffness ☐ sinus-like pressure

How often?

_____ days/month (or _____ days/week)

How long does a typical attack last?

_____ hours (or _____ days)

What reliably triggers it?

☐ poor sleep ☐ stress ☐ screens ☐ posture ☐ exercise ☐ dehydration ☐ caffeine changes
☐ menstrual cycle ☐ certain foods ☐ weather ☐ other: -----

What reliably helps?

☐ sleep ☐ dark/quiet room ☐ caffeine ☐ heat ☐ ice ☐ meds ☐ movement ☐ other:

Any prior head/neck injury?

☐ yes ☐ no If yes: -----

Questions to bring to your visit

- ☐ What headache types/patterns do I most likely have?
- ☐ What are the top 1–2 drivers for me (sleep, neck, nerve irritation, inflammation, medication overuse, etc.)?
- ☐ What should I do for a flare right now—and what should I do long-term?
- ☐ How will we measure progress?
- ☐ When would imaging or referral be necessary?

14-Day Headache Diary (simple version)

Complete this for the next 14 days and bring it to your visit. Patterns are often more visible on paper than in memory.

Date	Headache? (Y/N)	Peak severity (0–10)	Migraine features?*	Acute meds used?	Notes (sleep, stress, posture, food, cycle, etc.)

*Migraine features can include nausea, light sensitivity, sound sensitivity, throbbing/pulsing pain, or worse with activity. (This is not a diagnosis—just a tracking clue.)

Ready to get answers?

Whether your headaches are migraine, neck-driven, nerve-related, or a mix, our team is built to take a true differential diagnosis approach and coordinate evidence-based care under one roof.

That can include medical optimization, rehabilitation/physical therapy, targeted interventional options, functional medicine/nutrition, infusion support, and behavioral health/pain psychology—when appropriate.

If you're ready for clarity and a plan that lasts, schedule a comprehensive **Headache & Neck Evaluation**.

What to expect in your first visit

A thorough history and exam (including head/neck mechanics and nerve-related findings).

A clear working diagnosis and prioritized driver list.

A step-by-step plan with measurable goals.

Contact Rejuv Medical:

Website: <https://www.rejuvmedical.com/>

Email: frontdesk@rejuvmedical.com

Waite Park Clinic: 901 3rd Street North, Waite Park, MN 56387 | Ph: 320-217-8480

Edina Clinic: 7373 France Ave S, Suite 606, Edina, MN 55435 | Ph: 952-777-3899

New patient paperwork (optional but helpful): [Download the New Patient Packet \(PDF\)](#)

Note: Clinic contact information and paperwork links are provided for convenience; always follow the instructions given by your scheduling team.

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In-text citations use author–date format. Links below are included for convenient digital access.

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