MADISON NEUROLOGY · NEUROLOGY SYMPTOM GUIDE

Recurrent or chronic headache

Structured history, interpretation & clinical review

Symptom 3 of 94
Clinical educational workbook
Version 1.0 · October 2026

Not for clinical use. This guide cannot diagnose, triage, or exclude an emergency. Seek emergency care for severe, sudden, or worsening symptoms.

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> **Document purpose**
> A structured educational history and diagnostic-reasoning workbook. Treatment is outside its scope.

Scope and safe use

Headache phenotyping depends on tempo, attack pattern, associated symptoms, positional or exertional behavior, and change from any previous headache.

Not for clinical use.
This educational workbook does not diagnose, triage, estimate probability, replace examination, or exclude an emergency. If a safety-screen answer is Yes or uncertain, follow the stated action rather than continuing routine interpretation.

How to complete the workbook

- Record the current episode and the person’s usual baseline; use a witness account for events with impaired awareness.
- Check one option per question unless a clinician documents a different combination. “Not sure” is unresolved information, not a negative answer.
- Complete the safety screen before all other sections. Record exact onset or last-known-well time for sudden deficits.
- Use Section 2 only after the form is complete. More than one pattern may be relevant; urgency takes precedence.
- Use Section 3 to plan focused examination and clinician-selected investigations. No test is automatic or universally required.

Specific escalation rule

New severe headache, new focal weakness or numbness, new speech/language difficulty, reduced consciousness, a prolonged seizure, severe breathing or swallowing difficulty, sudden visual loss, or rapidly progressive weakness requires emergency assessment. Call 911 in the United States.

Section 1: Input form

Checkbox history for Recurrent or chronic headache

1A. Immediate safety screen

Did the headache reach maximal intensity within one minute, or is it unlike any previous headache?

☐ No ☐ Yes ☐ Not sure

If Yes: Seek emergency assessment now. Do not wait for a routine appointment or rely on pain relief as a test.

Is there new weakness, numbness, confusion, fainting, seizure, double vision, or difficulty speaking?

☐ No ☐ Yes ☐ Not sure

If Yes: Call emergency services now and record the onset or last-known-well time.

Is there fever with neck stiffness, a new rash, persistent vomiting, or marked light sensitivity?

☐ No ☐ Yes ☐ Not sure

If Yes: Seek emergency assessment now, especially if the person is drowsy, confused, or rapidly worsening.

Is there new visual loss, severe pain on eye movement, pregnancy/postpartum status, cancer, immunosuppression, or anticoagulant use with this headache?

☐ No ☐ Yes ☐ Not sure

If Yes: Arrange emergency or same-day assessment depending on severity; new visual loss or neurological symptoms require emergency care.

> **Stop rule:** Any Yes answer triggers the action printed under that question. Any Not sure answer requires prompt in-person clarification; do not treat it as No.

1B. Timeline

How did the symptom begin?

☐ Suddenly, over seconds or minutes ☐ Over hours to days ☐ Gradually over weeks or months ☐ Longstanding or since childhood ☐ Not sure

Use the first occurrence for recurrent episodes; use the current episode for a changing symptom.

What is the overall course?

☐ One persistent episode ☐ Separate recurrent episodes ☐ Steadily worsening ☐ Fluctuating or variable ☐ Currently resolved

Has this exact pattern been assessed before?

☐ Definitely new ☐ The same pattern occurred before ☐ Present and stable for a long time ☐ Not sure

1C. Discriminating features

Which headache pattern is most prominent?

☐ Throbbing with nausea or light/sound sensitivity ☐ Bilateral pressing or tightening ☐ Daily or near-daily persistent pain ☐ A clear change from a previous pattern

Does posture, coughing, or exertion reliably change the headache?

☐ Worse upright and better lying down ☐ Worse lying flat or on waking ☐ Triggered by cough, bending, or strain ☐ No clear trigger ☐ Not sure

How long does a typical attack last?

☐ Seconds to minutes ☐ 4–72 hours ☐ Longer than 72 hours or continuous ☐ Not sure

How often are acute pain medicines or combination analgesics used?

☐ Rarely or never ☐ On 10 or more days per month ☐ Daily or near-daily ☐ Not sure

1D. Associated findings

Are there other neurological symptoms—weakness, numbness, speech change, double vision, swallowing difficulty, or severe imbalance?

☐ Yes ☐ No ☐ Not sure

Are there systemic clues—fever, weight loss, cancer, infection risk, pregnancy/postpartum status, or a new medication?

☐ Yes ☐ No ☐ Not sure

How much does this affect daily activity?

☐ Noticeable but activities continue ☐ Some activities are limited ☐ Cannot perform usual activities ☐ Not sure

1E. Clinical context

Who is being assessed?

☐ Adult or adolescent ☐ Child under 12 ☐ Adult aged 65 or older

Could a medicine, substance, withdrawal, or recent dose change be relevant?

☐ No plausible contributor ☐ Yes or possibly ☐ Not reviewed

Include sedatives, dopamine-blocking drugs, stimulants, decongestants, anticholinergics, alcohol, and non-prescribed substances when relevant.

Is there a relevant neurological, muscular, metabolic, cardiovascular, autoimmune, or sleep disorder?

☐ No known relevant condition ☐ Yes ☐ Not sure

What prior information is available?

☐ A previous examination or investigation ☐ Prior records but no clear explanation ☐ No useful prior assessment ☐ Not sure

Additional history and documentation

Record exact dates/times, witness details, relevant medication doses and changes, prior investigation reports, and the person’s baseline function.

Section 2: Interpreting the input form

Answer combinations generate a differential and an assessment pathway—not a diagnosis.

> **Precedence:** Emergency safety answers override every pattern below. Otherwise, the highest-urgency fully matched pattern takes precedence. If entries are incomplete, contradictory, or match no pattern, use the unresolved-information pathway.

Pattern 1: Migraine-like recurrent pattern

Which headache pattern is most prominent? Throbbing with nausea or light/sound sensitivity
What is the overall course? Separate recurrent episodes

Structured clinical review pattern — Routine review

Recurrent throbbing attacks with migraine-associated features fit a primary-headache pattern if examination and context are reassuring.

Differential to review:

- Migraine or another recurrent primary headache
- Tension-type or cervicogenic headache

Action: Arrange a routine in-person clinical review. New, severe, or worsening symptoms change this pathway.

Pattern 2: Possible medication-overuse contribution

How often are acute pain medicines or combination analgesics used? On 10 or more days per month / Daily or near-daily
Which headache pattern is most prominent? Daily or near-daily persistent pain

Prompt clinical review pattern — Promptly

Frequent acute-medication use can sustain or complicate chronic headache and needs structured review.

Differential to review:

- Migraine or another recurrent primary headache
- Medication-overuse or secondary headache

Action: Arrange an in-person medical or neurological review promptly, usually within days. Seek sooner care if the pattern changes.

Pattern 3: Positional or pressure-related phenotype

Does posture, coughing, or exertion reliably change the headache? Worse upright and better lying down / Worse lying flat or on waking / Triggered by cough, bending, or strain

Prompt clinical review pattern — Promptly

A reproducible positional or Valsalva pattern directs attention to CSF-pressure or structural causes.

Differential to review:

- Medication-overuse or secondary headache

Action: Arrange an in-person medical or neurological review promptly, usually within days. Seek sooner care if the pattern changes.

Contingency: Document whether lying flat, standing, coughing, or bending predictably changes symptoms and bring prior scan reports.

Pattern 4: Changed or progressive headache

Which headache pattern is most prominent? A clear change from a previous pattern
What is the overall course? Steadily worsening

Urgent assessment pattern — Same day

A changed and progressively worsening headache is not managed as an unchanged primary-headache pattern.

Differential to review:

- Medication-overuse or secondary headache
- Giant cell arteritis or another inflammatory cause

Action: Arrange same-day medical assessment. If symptoms are rapidly worsening or severe, call 911.

Unresolved-information pathway: The entries need structured in-person characterization.

Prompt clinical review pattern — Promptly

Do not guess missing answers or convert uncertainty into reassurance. Document what is unknown, perform an in-person examination, clarify the timeline with a witness or records when available, and reassess if any new feature appears.

Action: Arrange an in-person medical or neurological review promptly, usually within days. Seek sooner care if the pattern changes.

Section 3: Clinical review

Diagnostic modules and focused investigation logic

The examination comes before a test list. Select investigations only after localization, urgency, comorbidity, pregnancy status, renal function, anticoagulation, and prior results have been considered.

3.1 Migraine or another recurrent primary headache

Discriminating features: Recurrent attacks with characteristic duration, sensory sensitivity, nausea, activity limitation, or aura; examine for atypical or progressive features.

Logical investigations: Headache diary, neurological examination, and review of attack frequency and medication use; imaging only when the phenotype or examination indicates it.

3.2 Tension-type or cervicogenic headache

Discriminating features: Bilateral pressure, pericranial tenderness, or a neck-linked mechanical pattern without the full migraine phenotype.

Logical investigations: Examination of neurological status, neck, jaw, and pericranial structures; assess functional and sleep contributors.

3.3 Medication-overuse or secondary headache

Discriminating features: Frequent analgesic use, a changed pattern, positional behavior, systemic illness, or abnormal examination raises a different pathway.

Logical investigations: Medication reconciliation and targeted examination; laboratory testing or imaging is guided by the suspected secondary mechanism.

3.4 Giant cell arteritis or another inflammatory cause

Discriminating features: New headache after age 50 with scalp tenderness, jaw claudication, visual symptoms, or systemic inflammation.

Logical investigations: Urgent clinical assessment with inflammatory markers and specialist-directed vascular or temporal-artery evaluation; visual symptoms are an emergency.

Reassessment and documentation

- If the symptom pattern changes, repeat the safety screen and timeline rather than carrying forward an earlier interpretation.
- If a test is unrevealing but the deficit persists or progresses, revisit localization and seek specialist review; a normal result does not automatically end assessment.
- If symptoms resolve, document duration, completeness of recovery, recurrence, and any residual deficit. Resolved sudden focal symptoms can still require urgent vascular assessment.
- If the history and examination conflict, obtain collateral information and in-person review rather than forcing a single diagnostic label.

Selected references

Sources provide background standards and do not replace local emergency pathways or current specialist guidance. Accessed October 2026.

1. National Institute for Health and Care Excellence. (2012, updated 2021). *Headaches in over 12s: diagnosis and management (CG150)*. https://www.nice.org.uk/guidance/cg150
2. National Institute for Health and Care Excellence. (2019, updated 2023). *Suspected neurological conditions: recognition and referral (NG127)*. https://www.nice.org.uk/guidance/ng127