

The first time a patient asked if their “cosmetic” Botox might also help their migraines, I pulled up their chart and counted 23 headache days in the last month. They had tried three oral preventives, two supplements, and a strict sleep schedule. What made the difference, eventually, was a structured medical botox treatment plan with the right dosing and a disciplined cycle. That is how onabotulinumtoxinA went from a wrinkle relaxing injection to a validated therapy for chronic migraine, one that can meaningfully change how many days a month you spend negotiating pain.

This guide focuses on the migraine protocol specifically, not cosmetic botox for forehead lines or crow’s feet. We will cover how botox for migraines works, the standard treatment cycle, what the procedure feels like, how results unfold over months, and how to troubleshoot plateaus. I will also explain how medical botox treatment differs from cosmetic botox, where techniques diverge, and what evidence supports the approach.

Why neurologists use Botox for chronic migraine

Botox, a brand name for onabotulinumtoxinA, is a neuromodulator injection derived from botulinum toxin type A. In cosmetic settings, botox cosmetic injections soften dynamic wrinkles by temporarily blocking acetylcholine release at the neuromuscular junction. That action relaxes targeted muscles and reduces creasing from repetitive movement, like frown lines and forehead lines. The migraine story is different.

In chronic migraine, sensory nerves release neuropeptides such as CGRP and substance P that amplify pain signaling and peripheral sensitization. When botox is injected at specific cranial and cervical sites, it reduces this peripheral nerve excitability by hindering the release of those pain mediators. It also lessens muscle tension in the pericranial region, which can contribute to a trigger threshold. The net effect is fewer migraine days and less severe flares over time. This is not a painkiller and not an acute rescue. It is a preventive therapy that needs a cycle to show its value.

Clinical trials that led to approval used a standardized injection map and dosing. Real-world results generally track those trials when the protocol is followed consistently, though individual response varies.

Who qualifies, and who should wait

Botox therapy is approved for chronic migraine, which is defined as at least 15 headache days per month for more than three months, with at least eight of those days having migraine features such as throbbing pain, light or sound sensitivity, nausea, or aura. If you have episodic migraine, averaging 4 to 10 days per month, other options usually come first. Some off-label cases exist, but insurers typically require the chronic criteria plus documentation of prior preventive attempts.

I often ask patients to keep a headache diary for six to eight weeks before the first botox procedure. It confirms baseline frequency and reveals patterns like weekend letdown headaches or menstrual clustering. The diary also helps us evaluate results later with a concrete before and after. If a patient recently started a CGRP monoclonal antibody, we may either layer botox when the baseline remains 15 or more days, or allow a trial period to see if the new drug alone reduces days sufficiently.

People with neuromuscular disorders, active infection at injection sites, or pregnancy should avoid botulinum toxin treatment unless a specialist advises otherwise. If someone has a history of significant neck weakness after neuromodulator injections, I adjust dosing and placement.

The PREEMPT protocol and how injections are mapped

The backbone of migraine botox is the PREEMPT protocol: 155 units across 31 sites, with up to 40 additional “follow-the-pain” units depending on the patient’s pattern. The sites include:

- Frontalis and corrugator/procerus region across the forehead and glabella, targeting the muscles that often drive frown lines but here aimed at sensory afferents near those muscles.
- Temporalis muscles, often tender in people who clench or grind.
- Occipital and paraspinal areas, including the suboccipital region, where trigger points can act as migraine launchpads.
- Trapezius muscles, upper fibers, for those with heavy shoulder and neck tension.

That is one of the few times cosmetic and medical botox treatment overlap anatomically. The purpose differs. In a cosmetic brow lift or botox for frown lines, injection depth and dilution aim for wrinkle reduction without affecting function beyond the aesthetic goal. In migraine, we target pain pathways and muscular contributors to migraine thresholds. Aesthetic placement might skip the occipital ridge, whereas the migraine map treats it routinely.

Expect small aliquots, generally 0.1 mL per site with a 30 or 32 gauge needle. In experienced hands, the botox procedure takes around 10 to 15 minutes.

What the appointment feels like

Patients often ask if botox injections hurt. Most describe a series of quick pinches or [Ann Arbor cosmetic botox](#) pressure, with extra sensitivity in the forehead and scalp. The trapezius area feels more like a dull poke deep in the muscle. I keep conversation going throughout so any dizziness or vagal response can be caught early. For those who dislike needles, I use distraction techniques, a cool pack over the next target area, and breathing pacing. Topical anesthetic is rarely needed.

After the injections, there is no required downtime. You can drive, work, and eat normally. I advise avoiding strenuous upper-body workouts, head-down yoga inversions, or deep massages of the injected areas for about 24 hours. This is not because botox migrates freely, but because tissue manipulation can increase local spread in a way that is harder to predict. Light walking is fine and often helpful.

The treatment cycle: timing, expectations, and why consistency matters

Botox for migraines has a cadence. The medication takes several days to bind, with clinical effects building from week two to week six. Unlike botox for wrinkles that visibly settles by day 7 to 10, migraine improvement frequently lags a bit longer and feels more gradual. Patients report fewer morning headaches, less need for triptans, and shorter attacks rather than a sudden off switch.

We schedule cycles every 12 weeks. That interval is based on the expected duration of effect and the clinical trial structure. Stretching beyond 12 weeks risks a rebound in headache days. Shortening significantly does not provide additional benefit and may raise the chance of adverse effects. Most patients need three cycles before we can call the response good, fair, or poor, because the benefit tends to stack across the first nine months.

If the baseline is 20 headache days per month, a first cycle might reduce it to 14 to 16 days. The second cycle often drops into the 10 to 12 range. By the third, many land at 6 to 10 days. That is an example, not a guarantee. I consider a 50 percent reduction in monthly migraine days a strong response. A 30 to 49 percent reduction is meaningful when attacks also become easier to treat. Less than 30 percent urges a careful review of placement, dose, adherence, sleep, and comorbid triggers.

How results are measured and what “success” looks like

Numbers matter here. Migraine care lives on frequency, severity, and disability. I ask patients to track:

- Headache days per month, separating migraine days from milder tension-type days.
- Triptan or gepant use and whether one dose aborts an attack.
- Function during attacks, such as ability to work or participate in family activities.

When the first few cycles are underway, patients often notice that even on headache days, their pain peaks lower and their rescue medicines work faster. That improved response is part of the value. It indicates that peripheral sensitization has eased, which aligns with how neuromodulator injections change the landscape for pain signaling.

Some patients see cosmetic changes as a byproduct: softer forehead lines, less frowning, a hint of a botox brow lift effect. While these can be welcome, they are not the priority and should not drive placement at the expense of migraine control. If a patient also wants botox for bunny lines or a botox lip flip, I handle those in separate visits or at the tail end of a migraine session only when we are certain the medical sites are fully covered.

Side effects to anticipate, and how to prevent most of them

The most common side effects are localized and short-lived. Scalp tenderness can last a day or two. Small bruises occur, especially in the forehead and temples. Neck stiffness or mild weakness sometimes follows injections in the posterior neck and trapezius. When that happens, I adjust the next dose or move the injection points slightly lateral or superior to spare deeper neck stabilizers.

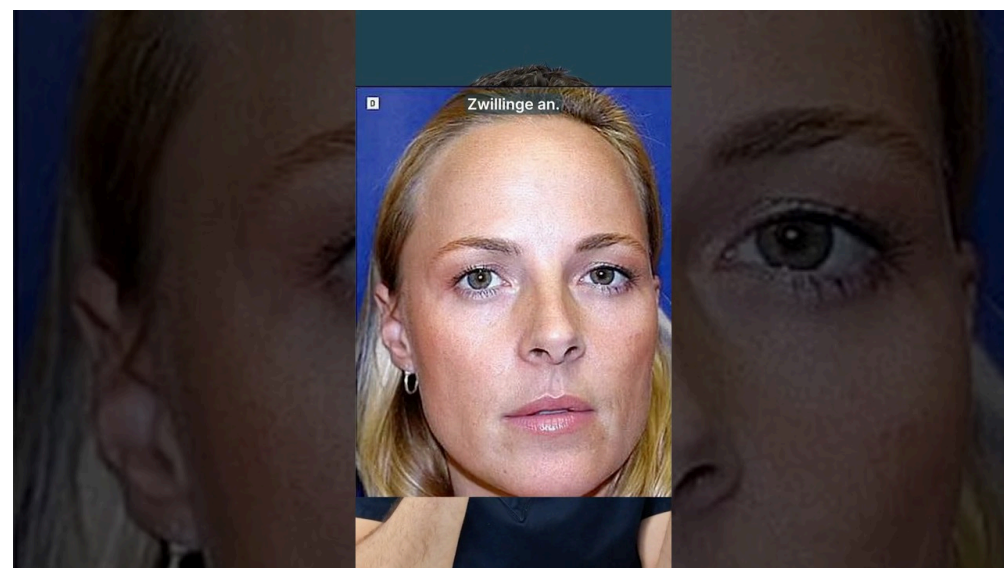


Flu-like feelings, low-grade headache, or a sense of heaviness may show up for 24 to 48 hours. True systemic effects are unusual at approved doses. Drooping eyelid (ptosis) is uncommon with the PREEMPT mapping, but it can happen if the frontalis and corrugator injections are placed too low or if there is unusual spread. Good technique and avoiding aggressive rubbing at the injection sites reduce that risk.

If patients use blood thinners, I use firmer pressure between injections and keep ice ready. Even then, bruising does not change [botox near me](#) the medication's effect.

How botox for migraines differs from other uses

The overlap between medical and cosmetic botox confuses people. A few points clarify the difference:



- Goal: In migraine, the goal is to reduce headache frequency and severity. In cosmetic botox or botox facial treatment, the aim is to soften lines from movement like botox for crow's feet or botox for frown lines.
- Dose: Migraine doses are higher, commonly 155 to 195 units, compared with 10 to 40 units for targeted aesthetic areas like botox for forehead lines or botox for smile lines.
- Sites: Migraine mapping includes the scalp, occipital region, and neck bands region of the trapezius. Cosmetic work might include anti wrinkle botox for neck bands, but with different dilution and placement.
- Cadence: Migraine cycles are fixed at 12 weeks. Cosmetic timing can stretch to 3 to 5 months depending on the area and personal goals.

Wrinkle relaxing injections, preventative botox, baby botox, and micro botox each refer to approaches and doses meant for aesthetics. They may improve how the face looks at rest and in motion, but they are not a substitute for the migraine protocol. Conversely, migraine botox may produce some aesthetic softening without the precision of targeted cosmetic planning.

Stacking therapies and when to combine with other treatments

Many patients do best with a layered plan. Combining botox for migraines with a CGRP monoclonal antibody is common in people who remain in the 8 to 12 days per month range after several cycles. Insurers vary in coverage policy, but clinically the combination can be synergistic because the mechanisms differ. Botox acts more peripherally on sensory terminals and muscle input. CGRP inhibitors block a specific peptide pathway.

For those with bruxism, masseter botox can reduce clenching and jaw pain that trigger nocturnal headaches. Doses are tailored to preserve chewing strength while limiting the overworked bulk of the masseter. In people with TMJ symptoms or teeth grinding, judicious botox for jaw clenching may remove a nightly spark that keeps trigeminal pathways sensitized.

If a patient has primary hyperhidrosis driving dehydration headaches during workouts, treating underarm or scalp sweating with botox for excessive sweating can indirectly help by stabilizing hydration and temperature. That is a separate indication but reflects how neuromodulator injections can support headache management outside the cranium.

What if botox seems to “stop working” or wear off faster

Two scenarios account for most plateaus. The first is pharmacologic drift as you approach week 10 or 11. Headaches can creep back before the 12-week mark. If the first 8 to 10 weeks are markedly better, we simply hold the schedule firm and use rescue plans for the last two weeks. The second is incomplete coverage of the patient’s individual pain pattern. For example, someone whose pain localizes to the vertex and behind the ears may need more coverage in the temporalis posterior fibers or occipital ridge. In that case, we add “follow-the-pain” units up to 195 total.

Neutralizing antibodies to botulinum toxin are uncommon at the doses used for migraine. When patients ask why botox stops working, I assess recent life changes first. Sleep loss, a new SSRI or stimulant, perimenopause, skipped meals, or extra travel can all lift the trigger load beyond what a set dose can buffer. I also make sure the dilution and brand are consistent. Differences between botox vs xeomin or the difference between botox and dysport can matter for aesthetics, but for migraine I stick with onabotulinumtoxinA used in the trials unless there is a compelling reason to switch.

Safety, long-term use, and what we actually see after years

Is botox safe long term for migraine? The data and clinical experience suggest yes when used at approved doses and intervals. I have patients who have stayed on botox therapy for five to eight years, cycling every 12 weeks. Muscles do not atrophy to a concerning degree when dosing is stable and the neck is handled with care. The most persistent issue I manage is mild trapezius weakness in people who lift heavy weights. We trim units in the trap and increase posterior scalp coverage to compensate.

Because botulinum toxin treatment wears off gradually, the nervous system respects the pattern. You do not need to “detox” or “reset.” If a patient wishes to stop after a year of stability, we watch the next three months closely with a diary. Some keep half the benefit for a while, implying that intervening in pain signaling created a new baseline. Others return to their prior frequency and choose to resume.

Setting realistic expectations for a first-timer

A first botox session for migraine is mostly logistics and planning. Thirty-one small injections can sound like a lot. In practice it feels like a series of quick taps. Bring a snack for after the visit if you tend to feel woozy with needles. Plan light activity for the rest of the day and avoid hot yoga, deep tissue massage, or long hair appointments that require head-down posture.

Results will begin quietly. Expect your first wins to be shorter flares and faster rescue. The headache diary will tell the story better than memory. We will compare month one to month three, then cycle two to cycle three. If we see progress, we stay the course. If progress stalls, we adjust dose and map.

Special circumstances: aura, vestibular migraine, and menstrual patterns

Patients with visual aura can still benefit, though aura frequency may not decline as much as pain days. Vestibular migraine patients often report fewer dizzy days once neck and occipital triggers settle, but results vary. For menstrual

migraine, botox tends to lower the baseline, which sometimes makes the perimenstrual window less explosive. I often add a short preventive bridge such as magnesium or an NSAID around menses to reinforce the cycle.

Where general “Botox rules” do and do not apply

A few myths float between cosmetic and medical use:

- Does botox freeze your face? In migraine dosing, we preserve function. You might notice less frowning, but your face should move. Frozen expression typically reflects aesthetic overdosing, not the migraine map.
- Can botox look natural? Yes. In migraine care, natural is the default because we are not chasing a wrinkle-free finish. If you also pursue botox for fine lines or facial balancing, communicate your preference for subtle changes. Preventative botox and baby botox in cosmetic contexts can look natural when placed thoughtfully.
- Can botox change face shape? Targeted masseter botox for jaw slimming will soften the jaw angle over several months. That is a separate choice, not part of migraine prevention. It can help when masseter hypertrophy drives clenching-related head pain, but dosing must respect function.
- Does botox help acne or lift sagging skin? Not directly. It may reduce oil a bit with micro botox, but that is an aesthetic microdroplet technique, not a migraine strategy. Botox does not lift sagging skin; fillers or devices address volume and laxity. Botox vs fillers is a common comparison, but for migraine, fillers have no role.

Practical cost and coverage notes

Coverage often requires documentation of chronic migraine diagnosis and prior trials of at least two oral preventives, such as a beta blocker or topiramate. Pre-authorization cycles can be tight. If a dose increase is planned, submit in advance. If your plan denies, appeal with a headache diary and prior medication records. For those paying out-of-pocket, costs vary by region and unit price. Remember the dose is higher than cosmetic sessions, so pricing is not directly comparable to botox for under eyes or a small botox brow lift.

A brief case pattern from clinic

A 34-year-old software engineer averaging 22 headache days per month, with worse pain at the end of long screen days, started botox after trying amitriptyline and propranolol. Cycle one brought her to 15 days. She noted less shoulder tightness and needed only one dose of her gepant on most migraine days. We added 20 follow-the-pain units to the temporalis and occipital sites for cycle two because her pain mapped to those areas. By cycle three, she averaged 9 days per month, usually lighter. She kept up walks at lunch, reduced back-to-back meetings, and stuck to the 12-week cadence. Two years later, she hovers at 6 to 8 days, with quick rescue success.

Not everyone responds that well, but the trajectory illustrates the stacked gains across cycles and the value of customizing the map.

A single list worth saving: your first three cycles, at a glance

- Keep a headache diary starting two weeks before the first visit, and do not stop until after cycle three.
- Expect gradual improvement, most noticeable between weeks 2 and 10 of each cycle.
- Return every 12 weeks without stretching the interval, even if you feel better.
- Report neck weakness, significant bruising, or new pain patterns so placement can be adjusted.
- Evaluate success after three cycles using frequency, severity, and rescue effectiveness, not just one metric.

How to make results last and keep quality of life high

Botox sets the floor. Daily habits still matter. Hydration, regular meals, consistent sleep, and light daily movement add stability. Screen breaks each hour reduce sustained trapezius load. If bruxism drives morning headaches, a night guard plus masseter botox may improve mornings. An honest look at caffeine shows whether the dose is helping or hampering. These are not platitudes, they are small hinges that move big doors when paired with neuromodulator injections.

If you also receive cosmetic work, coordinate timing so the migraine map is never compromised. Your provider should separate goals: botox for migraines first, then optional aesthetic touches like botox for gummy smile, botox for bunny lines, or botox under eyes if appropriate for your anatomy.

Final thoughts from the chair across the room

The most satisfying moment in this process is not a perfect forehead, it is when a patient realizes they scheduled their life without blocking “migraine days.” That relief comes from a predictable routine: the right map, the right dose, twelve-week cycles, and honest tracking. If you start, give it three cycles. Adjust where needed. Measure what matters. Migraine does not yield to one tool, but botox has earned its place as one of the most dependable preventives we have.

And if you still worry that neuromodulator injections will make you look frozen, remember the medical intention here. You are not chasing a wrinkle, you are resetting a pain circuit. Done well, your face still looks like you. Your calendar, though, looks different.