MADISON NEUROLOGY · NEUROLOGY SYMPTOM GUIDE

A change in personality, behavior, judgment, or level of functioning

Structured history, interpretation & clinical review

Symptom 60 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

A change in personality, behavior, judgment, or functioning is assessed by tempo, cognition, safety, sleep, medication/substances, mood/psychosis, movement, and focal neurological signs.

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 A change in personality, behavior, judgment, or level of functioning

1A. Immediate safety screen

Is the person acutely confused, struggling to breathe, having a seizure, or difficult to awaken?

☐ No ☐ Yes ☐ Not sure

If Yes: Call emergency services now.

Is there new one-sided weakness, facial droop, severe imbalance, or speech/language difficulty?

☐ No ☐ Yes ☐ Not sure

If Yes: Call emergency services now and record the onset time.

Is there sudden visual loss or a new painful red eye?

☐ No ☐ Yes ☐ Not sure

If Yes: Seek emergency eye or emergency-department assessment now.

Is there fever with rapidly worsening illness, a new rash, severe dehydration, or an inability to keep fluids down?

☐ No ☐ Yes ☐ Not sure

If Yes: Arrange same-day or emergency assessment depending on severity and current consciousness.

> **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 change is most prominent?

☐ Disinhibition, impulsivity, or loss of social judgment ☐ Apathy, withdrawal, or loss of initiative ☐ Hallucinations, delusions, or marked suspiciousness ☐ Decline in work, self-care, or familiar roles

How quickly did it emerge?

☐ Hours to days ☐ Days to weeks ☐ Months or years ☐ Discrete recurrent episodes

Is there aggression, self-harm risk, inability to care for basic needs, or severe sleep loss?

☐ Yes ☐ No ☐ Not sure

Are there cognitive, movement, sleep, medication, or neurological clues?

☐ Memory/executive change ☐ Tremor, stiffness, gait, or involuntary movements ☐ Major sleep change or dream enactment ☐ Medication or substance change ☐ None

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: Acute behavior change or safety-risk pathway

How quickly did it emerge? Hours to days / Days to weeks
Is there aggression, self-harm risk, inability to care for basic needs, or severe sleep loss? Yes

Emergency warning pattern — Now

Acute behavior change with safety risk or loss of basic function requires urgent in-person assessment.

Differential to review:

- Delirium, intoxication/withdrawal, or acute neurological process
- Mood, psychotic, trauma-related, or sleep disorder

Action: Call 911 or go to the nearest emergency department now. Do not drive yourself.

Pattern 2: Acute neurological/medical behavior change

How quickly did it emerge? Hours to days / Days to weeks

Urgent assessment pattern — Same day

Acute/subacute change requires medical, medication, and neurological causes to be assessed before a chronic label.

Differential to review:

- Delirium, intoxication/withdrawal, or acute neurological process
- Structural, autoimmune, endocrine, or medication-related behavior disorder

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

Pattern 3: Progressive neurodegenerative behavior pattern

How quickly did it emerge? Months or years
Are there cognitive, movement, sleep, medication, or neurological clues? Memory/executive change / Tremor, stiffness, gait, or involuntary movements / Major sleep change or dream enactment

Prompt clinical review pattern — Promptly

Gradual behavior change with cognitive, movement, or sleep features follows a neurodegenerative assessment.

Differential to review:

- Frontotemporal, Alzheimer, Lewy-body, or other neurodegenerative disorder

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

Pattern 4: Episodic behavior or mood/sleep pattern

How quickly did it emerge? Discrete recurrent episodes
Are there cognitive, movement, sleep, medication, or neurological clues? Major sleep change or dream enactment / None

Prompt clinical review pattern — Promptly

Recurrent discrete behavior changes need event-level sleep, seizure, mood, and substance characterization.

Differential to review:

- Mood, psychotic, trauma-related, or sleep disorder
- Delirium, intoxication/withdrawal, or acute neurological process

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

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 Delirium, intoxication/withdrawal, or acute neurological process

Discriminating features: Acute/subacute behavior change with inattention, focal signs, infection, drug change, or reduced consciousness.

Logical investigations: Urgent medical and neurological assessment with targeted metabolic, toxicology, infection, imaging or EEG evaluation as indicated.

3.2 Frontotemporal, Alzheimer, Lewy-body, or other neurodegenerative disorder

Discriminating features: Gradual disinhibition/apathy, hallucinations, cognitive/functional decline, movement or REM-sleep clues.

Logical investigations: Collateral cognitive/behavior history, neurological examination, MRI and specialist cognitive assessment.

3.3 Mood, psychotic, trauma-related, or sleep disorder

Discriminating features: Episodic mood change, psychosis, severe insomnia, or stress/trauma context after medical causes are considered.

Logical investigations: Safety, psychiatric, sleep and medication assessment; urgent care for self-harm, violence, or inability to maintain basic needs.

3.4 Structural, autoimmune, endocrine, or medication-related behavior disorder

Discriminating features: Subacute progression, new drugs, seizures, movement findings, or systemic/endocrine clues.

Logical investigations: Targeted laboratory, brain MRI and selected immune/infectious testing based on the clinical phenotype.

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. (2018, updated 2025). *Dementia: assessment, management and support for people living with dementia and their carers (NG97)*. https://www.nice.org.uk/guidance/ng97
2. National Institute for Health and Care Excellence. (2010, updated 2023). *Delirium: prevention, diagnosis and management in hospital and long-term care (CG103)*. https://www.nice.org.uk/guidance/cg103