MADISON NEUROLOGY · NEUROLOGY SYMPTOM GUIDE

Collapse or fall without clear loss of consciousness

Structured history, interpretation & clinical review

Symptom 65 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

Fainting, collapse, and transient loss of consciousness are separated by posture/exertion, prodrome, witnessed movements, recovery, cardiac clues, injury, and neurological events.

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 Collapse or fall without clear loss of consciousness

1A. Immediate safety screen

Is there chest pain, severe breathlessness, palpitations with collapse, or collapse during exertion?

☐ No ☐ Yes ☐ Not sure

If Yes: Call emergency services now.

Is there new focal weakness, severe headache, confusion, or difficulty speaking?

☐ No ☐ Yes ☐ Not sure

If Yes: Call emergency services now.

Is there black or bloody stool, heavy bleeding, severe abdominal pain, or pregnancy with collapse?

☐ No ☐ Yes ☐ Not sure

If Yes: Seek emergency assessment now.

Did collapse cause significant injury, or is the person still confused or unresponsive?

☐ No ☐ Yes ☐ Not sure

If Yes: Seek emergency assessment now.

> **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

Was there definite loss of consciousness?

☐ Yes, confirmed by the person or witness ☐ Unclear; collapse without a clear account ☐ No, near-collapse only

What was happening immediately before?

☐ Standing, heat, pain, fear, or prolonged upright posture ☐ Exercise or exertion ☐ Sitting/lying without exertion ☐ Not sure

Which preceding features occurred?

☐ Warmth, nausea, sweating, visual dimming ☐ Palpitations, chest pain, or breathlessness ☐ Smell/taste, fear, rising sensation, or focal neurological aura ☐ No warning

What happened during and after?

☐ Brief episode with rapid recovery ☐ Prolonged confusion or sleepiness ☐ Brief jerks only after collapse ☐ Sustained rhythmic convulsion or tongue bite

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: Classic reflex-syncope pattern

What was happening immediately before? Standing, heat, pain, fear, or prolonged upright posture
Which preceding features occurred? Warmth, nausea, sweating, visual dimming
What happened during and after? Brief episode with rapid recovery / Brief jerks only after collapse

Prompt clinical review pattern — Promptly

A situational trigger, classic prodrome, and rapid recovery support reflex syncope after ECG and injury assessment.

Differential to review:

- Reflex syncope

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

Pattern 2: Exertional or cardiac-pattern collapse

What was happening immediately before? Exercise or exertion / Sitting/lying without exertion
Which preceding features occurred? Palpitations, chest pain, or breathlessness / No warning

Emergency warning pattern — Now

Exertional/supine collapse or cardiac symptoms require urgent cardiac assessment.

Differential to review:

- Cardiac syncope or arrhythmia

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

Pattern 3: Seizure-pattern episode

Which preceding features occurred? Smell/taste, fear, rising sensation, or focal neurological aura
What happened during and after? Prolonged confusion or sleepiness / Sustained rhythmic convulsion or tongue bite

Urgent assessment pattern — Same day

An aura with sustained convulsion or prolonged confusion requires seizure-pathway assessment.

Differential to review:

- Epileptic seizure or another neurological episode

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

Pattern 4: Unclear collapse without reliable loss-of-consciousness account

Was there definite loss of consciousness? Unclear; collapse without a clear account

Prompt clinical review pattern — Promptly

Collapse without clear loss of consciousness needs separate mechanical-fall, syncope, seizure, and functional-event assessment.

Differential to review:

- Cardiac syncope or arrhythmia
- Epileptic seizure or another neurological episode
- Orthostatic hypotension, metabolic, medication, or functional collapse

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.

Urgent assessment pattern — Same day

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

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 Reflex syncope

Discriminating features: Standing/situational trigger, vasovagal prodrome, brief collapse and rapid recovery; brief secondary jerks can occur.

Logical investigations: History, examination and ECG; assess injury and atypical cardiac/neurological features.

3.2 Cardiac syncope or arrhythmia

Discriminating features: Exertional or supine collapse, palpitations/chest symptoms, no prodrome, or structural heart disease.

Logical investigations: Urgent ECG and cardiovascular evaluation; exertional or symptomatic collapse may require emergency care.

3.3 Epileptic seizure or another neurological episode

Discriminating features: Aura, sustained convulsion, marked postictal confusion, focal signs, or stereotyped recurrence.

Logical investigations: Neurological assessment with EEG/MRI when supported; do not diagnose seizure from jerking alone.

3.4 Orthostatic hypotension, metabolic, medication, or functional collapse

Discriminating features: Standing-related symptoms, drug effects, hypoglycemia, anemia/bleeding, or inconsistent event features.

Logical investigations: Orthostatic vitals, glucose/blood count/metabolic and medication review; event documentation for unexplained recurrences.

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. (2010, updated 2023). *Transient loss of consciousness (“blackouts”) in over 16s (CG109)*. https://www.nice.org.uk/guidance/cg109
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