MADISON NEUROLOGY · NEUROLOGY SYMPTOM GUIDE

Difficulty initiating or maintaining sleep

Structured history, interpretation & clinical review

Symptom 88 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.

Contents

Scope and safe use 3

Section 1: Input form 4

1A. Immediate safety screen 4

1B. Timeline 4

1C. Discriminating features 4

1D. Associated findings 5

1E. Clinical context 5

Section 2: Interpreting the input form 7

Section 3: Clinical review 9

Selected references 11

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

Scope and safe use

Difficulty initiating or maintaining sleep is assessed by duration, schedule, sleep opportunity, daytime impact, apnea/movement clues, circadian timing, medication/substances, and mood or medical symptoms.

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 Difficulty initiating or maintaining sleep

1A. Immediate safety screen

Is there current severe breathlessness, blue lips, chest pain, or inability to awaken?

☐ No ☐ Yes ☐ Not sure

If Yes: Call emergency services now.

Is the person falling asleep while driving, operating machinery, or doing another safety-critical activity?

☐ No ☐ Yes ☐ Not sure

If Yes: Stop the activity now and arrange prompt assessment; do not drive until the safety issue has been evaluated.

Is there new focal weakness, sudden severe headache, confusion, or a prolonged seizure?

☐ No ☐ Yes ☐ Not sure

If Yes: Call emergency services now.

Has a sleep behavior caused serious injury, or is there a new prolonged unresponsive episode?

☐ No ☐ Yes ☐ Not sure

If Yes: Seek emergency or same-day assessment depending on current responsiveness and injury severity.

> **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

What is the main sleep difficulty?

☐ Difficulty falling asleep ☐ Frequent or prolonged waking ☐ Early waking with inability to return ☐ A mixed pattern

How long has it been present?

☐ Less than three months or linked to a stressor ☐ At least three months ☐ Since childhood or adolescence ☐ Not sure

What is the sleep/wake schedule?

☐ Regular with adequate time in bed ☐ Much later sleep/wake preference ☐ Shift work or highly irregular timing ☐ Excess time in bed or irregular napping

Are there snoring/apneas, restless legs, pain, mood symptoms, caffeine/alcohol, or relevant medicines?

☐ Snoring or breathing pauses ☐ Urge to move legs or periodic movements ☐ Mood, anxiety, pain, or stress ☐ Caffeine, alcohol, or medicine ☐ 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: Circadian or schedule-driven pattern

What is the sleep/wake schedule? Much later sleep/wake preference / Shift work or highly irregular timing / Excess time in bed or irregular napping

Structured clinical review pattern — Routine review

A delayed, irregular, or opportunity-limiting schedule requires circadian/sleep-diary assessment.

Differential to review:

- Circadian rhythm or insufficient-opportunity pattern

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

Pattern 2: Coexisting sleep-disorder clue

Are there snoring/apneas, restless legs, pain, mood symptoms, caffeine/alcohol, or relevant medicines? Snoring or breathing pauses / Urge to move legs or periodic movements

Prompt clinical review pattern — Promptly

Breathing or leg-movement clues require a specific coexisting sleep-disorder assessment.

Differential to review:

- Sleep apnea, restless legs, pain, or medical contributor

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

Pattern 3: Mood, pain, or substance-associated insomnia

Are there snoring/apneas, restless legs, pain, mood symptoms, caffeine/alcohol, or relevant medicines? Mood, anxiety, pain, or stress / Caffeine, alcohol, or medicine

Prompt clinical review pattern — Promptly

Mood, pain, caffeine, alcohol, or medication clues direct contributor-specific assessment.

Differential to review:

- Medication, substance, mood, or anxiety-related insomnia
- Sleep apnea, restless legs, pain, or medical contributor

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

Pattern 4: Persistent insomnia without another clue

How long has it been present? At least three months
Are there snoring/apneas, restless legs, pain, mood symptoms, caffeine/alcohol, or relevant medicines? None

Structured clinical review pattern — Routine review

Persistent sleep difficulty with adequate opportunity and no other clue follows a structured insomnia assessment.

Differential to review:

- Chronic insomnia disorder

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

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

Structured clinical review pattern — Routine review

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

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 Chronic insomnia disorder

Discriminating features: Persistent sleep difficulty despite adequate opportunity with daytime consequences and no better explanation.

Logical investigations: Sleep diary, daytime-impact and contributing-factor assessment; structured insomnia-focused clinical evaluation.

3.2 Circadian rhythm or insufficient-opportunity pattern

Discriminating features: Delayed/irregular schedule, shift work, excess time in bed, or mismatch between sleep timing and obligations.

Logical investigations: Sleep/wake diary and schedule assessment; actigraphy when circadian timing is uncertain.

3.3 Sleep apnea, restless legs, pain, or medical contributor

Discriminating features: Breathing pauses, leg urges/movements, pain, nocturia, or systemic symptoms fragment sleep.

Logical investigations: Targeted sleep-apnea, RLS, medical, and pain evaluation rather than assuming primary insomnia.

3.4 Medication, substance, mood, or anxiety-related insomnia

Discriminating features: Caffeine, stimulants, alcohol, withdrawal, activating/sedating drugs, or mood/anxiety symptoms.

Logical investigations: Substance/medication and mental-health review with safety assessment when severe sleep loss or self-harm risk occurs.

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. (2021, updated 2024). *Obstructive sleep apnoea/hypopnoea syndrome and obesity hypoventilation syndrome in over 16s (NG202)*. https://www.nice.org.uk/guidance/ng202
2. Winkelman JW, Berkowski JA, DelRosso LM, et al.. (2025). *Treatment of restless legs syndrome and periodic limb movement disorder: an American Academy of Sleep Medicine clinical practice guideline*. https://pubmed.ncbi.nlm.nih.gov/39324694/