MADISON NEUROLOGY · NEUROLOGY SYMPTOM GUIDE

Generalized fatigue or low energy

Structured history, interpretation & clinical review

Symptom 22 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

Fatigue is documented separately from true weakness by energy, sleepiness, exertional intolerance, task failure, and systemic or psychological context.

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 Generalized fatigue or low energy

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 description is closest?

☐ Tiredness or low energy ☐ A strong need to sleep or unintended sleep ☐ Exhaustion after minimal exertion ☐ A specific movement cannot be performed

How is sleep quantity and quality?

☐ Insufficient time for sleep ☐ Long or unrefreshing sleep ☐ Frequent waking or insomnia ☐ Usually restorative

Are there systemic, medication, mood, or nutritional clues?

☐ Fever, weight change, pain, or another physical symptom ☐ New medicine or substance ☐ Low mood, anxiety, grief, or major stress ☐ None identified

How has activity changed?

☐ Reduced but stable ☐ Marked delayed worsening after exertion ☐ Unable to manage basic daily activity ☐ Usual activity maintained

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: Sleep-centered fatigue

Which description is closest? A strong need to sleep or unintended sleep
How is sleep quantity and quality? Insufficient time for sleep / Long or unrefreshing sleep / Frequent waking or insomnia

Prompt clinical review pattern — Promptly

Unintended sleep or unrefreshing/insufficient sleep directs assessment toward a sleep disorder or sleep deficiency.

Differential to review:

- Sleep deficiency, sleep disorder, or circadian cause

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

Pattern 2: Systemic or medication-associated fatigue

Are there systemic, medication, mood, or nutritional clues? Fever, weight change, pain, or another physical symptom / New medicine or substance

Prompt clinical review pattern — Promptly

A systemic or exposure clue targets initial medical assessment and testing.

Differential to review:

- Systemic, metabolic, nutritional, or medication-related fatigue

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

Pattern 3: Post-exertional and function-limiting fatigue

How has activity changed? Marked delayed worsening after exertion / Unable to manage basic daily activity

Prompt clinical review pattern — Promptly

Major functional change or delayed post-exertional worsening needs careful medical and functional characterization.

Differential to review:

- Systemic, metabolic, nutritional, or medication-related fatigue
- Mood, stress, pain, or persistent post-exertional symptoms

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

Pattern 4: Specific task failure

Which description is closest? A specific movement cannot be performed

Urgent assessment pattern — Same day

A specific inability to perform movement is true weakness until assessed and should not remain in a nonspecific fatigue pathway.

Differential to review:

- True neuromuscular or neurological weakness

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.

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 Sleep deficiency, sleep disorder, or circadian cause

Discriminating features: Unrefreshing/short sleep, insomnia, apnea clues, or unintended sleep supports a sleep-centered evaluation.

Logical investigations: Sleep schedule and diary, apnea/narcolepsy screening, and targeted sleep testing when indicated.

3.2 Systemic, metabolic, nutritional, or medication-related fatigue

Discriminating features: Systemic symptoms, intake change, anemia risk, thyroid disease, infection, or drug effects.

Logical investigations: Focused examination and targeted blood count, metabolic/thyroid/nutritional testing based on clues—not indiscriminate panels.

3.3 Mood, stress, pain, or persistent post-exertional symptoms

Discriminating features: Mood/stress context, chronic pain, infection aftermath, and delayed post-exertional worsening shape assessment.

Logical investigations: Function, mood, pain and exertion history; evaluate physical contributors and avoid attributing objective weakness solely to mood.

3.4 True neuromuscular or neurological weakness

Discriminating features: Specific task failure, fatigable ocular/bulbar symptoms, atrophy, or abnormal examination.

Logical investigations: Objective motor examination; CK, electrodiagnostics, imaging, or neuromuscular referral according to localization.

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/