MADISON NEUROLOGY · NEUROLOGY SYMPTOM GUIDE

Jerking, writhing, flailing, or other involuntary movements

Structured history, interpretation & clinical review

Symptom 72 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 10

Selected references 12

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

Scope and safe use

Jerking, writhing, flailing, tics, and other involuntary movements are classified by speed, suppressibility, rhythm, distribution, triggers, awareness, medication, and development.

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 Jerking, writhing, flailing, or other involuntary movements

1A. Immediate safety screen

Is there new face droop, one-sided weakness or numbness, difficulty speaking or understanding, double vision, or severe loss of coordination?

☐ No ☐ Yes ☐ Not sure

If Yes: Call emergency services now and record the exact time the person was last known well.

Is there new confusion, reduced consciousness, a seizure, or difficulty awakening?

☐ No ☐ Yes ☐ Not sure

If Yes: Call emergency services now. Do not leave the person alone or give food, drink, or medication by mouth.

Is there new severe breathlessness, inability to swallow saliva, blue lips, or rapidly worsening weakness?

☐ No ☐ Yes ☐ Not sure

If Yes: Call emergency services now; breathing and swallowing problems can become critical quickly.

Is there sudden loss of vision, a new missing visual field, or a painful red eye?

☐ No ☐ Yes ☐ Not sure

If Yes: Seek emergency eye or emergency-department 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

Which movement form dominates?

☐ Sudden brief jerks ☐ Slow writhing or flowing movements ☐ Large proximal flailing movements ☐ Repetitive patterned movements or vocalizations

Can movements be suppressed, and is there an urge?

☐ An urge with temporary suppression and relief ☐ Brief suppression without a clear urge ☐ Not suppressible ☐ Not sure

Is awareness altered, or do movements occur during sleep?

☐ Altered awareness ☐ Only or mainly during sleep ☐ Fully awake and aware ☐ Not sure

Is there a new medicine, infection, developmental history, or family history?

☐ New or long-term medicine ☐ Began in childhood ☐ Family history of similar movement ☐ None identified

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: Urge-linked suppressible tic pattern

Which movement form dominates? Repetitive patterned movements or vocalizations
Can movements be suppressed, and is there an urge? An urge with temporary suppression and relief
Is there a new medicine, infection, developmental history, or family history? Began in childhood

Structured clinical review pattern — Routine review

Repetitive suppressible movements with an urge and childhood pattern support a tic-disorder assessment.

Differential to review:

- Tic disorder or stereotypy

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

Pattern 2: Acute flailing or focal involuntary movement

Which movement form dominates? Large proximal flailing movements
How did the symptom begin? Suddenly, over seconds or minutes

Emergency warning pattern — Now

Sudden large focal flailing movements require emergency vascular and metabolic assessment.

Differential to review:

- Myoclonus, chorea, hemiballismus, or another hyperkinetic neurological disorder

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

Pattern 3: Medication-associated movement pattern

Is there a new medicine, infection, developmental history, or family history? New or long-term medicine

Prompt clinical review pattern — Promptly

A relevant medication exposure directs assessment for drug-induced dyskinesia, akathisia, dystonia, or withdrawal movements.

Differential to review:

- Medication-induced dyskinesia, akathisia, dystonia, or withdrawal emergent movement

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

Pattern 4: Jerk or writhing neurological pattern

Which movement form dominates? Sudden brief jerks / Slow writhing or flowing movements
Is awareness altered, or do movements occur during sleep? Fully awake and aware

Prompt clinical review pattern — Promptly

Jerking or writhing while fully aware requires hyperkinetic movement localization and cause assessment.

Differential to review:

- Myoclonus, chorea, hemiballismus, or another hyperkinetic neurological disorder
- Seizure, sleep-related, metabolic, autoimmune, or functional movement event

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

Pattern 5: Events with altered awareness or sleep linkage

Is awareness altered, or do movements occur during sleep? Altered awareness / Only or mainly during sleep

Urgent assessment pattern — Same day

Altered awareness or sleep-locked movements need seizure and sleep-event characterization.

Differential to review:

- Seizure, sleep-related, metabolic, autoimmune, or functional movement event

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.

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 Myoclonus, chorea, hemiballismus, or another hyperkinetic neurological disorder

Discriminating features: Brief jerks, flowing chorea, or large flailing movements with characteristic distribution.

Logical investigations: Neurological examination; acute focal movements may need urgent brain imaging, with metabolic/toxic/immune testing as indicated.

3.2 Tic disorder or stereotypy

Discriminating features: Repetitive patterned movements/vocalizations with urge and suppressibility, often childhood onset.

Logical investigations: Developmental and family history, examination, and assessment of attention, learning, mood, and functional impact.

3.3 Medication-induced dyskinesia, akathisia, dystonia, or withdrawal emergent movement

Discriminating features: Temporal relation to dopamine-blocking, antiemetic, stimulant, or other medicines.

Logical investigations: Detailed current/past drug exposure and movement examination; severe acute dystonia or systemic signs require urgent care.

3.4 Seizure, sleep-related, metabolic, autoimmune, or functional movement event

Discriminating features: Altered awareness, sleep relation, metabolic/immune context, or positive functional movement features.

Logical investigations: Event video/witness history and targeted EEG, metabolic, immune or sleep assessment according to 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. (2017, updated 2025). *Parkinson's disease in adults (NG71)*. https://www.nice.org.uk/guidance/ng71

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