MADISON NEUROLOGY · NEUROLOGY SYMPTOM GUIDE

# Numbness or weakness-like “deadness” of one side of the body

Structured history, interpretation & clinical review

Symptom 24 of 94

Clinical educational workbook

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**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

Focal numbness or tingling is localized by body side, nerve/root territory, cortical associations, tempo, and objective sensory change.

**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 Numbness or weakness-like “deadness” of one side of the body

## 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 sensory map fits best?**

☐ Face and/or one whole side of the body ☐ Specific fingers or one hand ☐ A band down one arm or leg ☐ One isolated skin patch

**What is the predominant experience?**

☐ Actual reduced feeling ☐ Tingling or pins and needles ☐ Weakness-like deadness without clear sensory testing ☐ Painful burning or hypersensitivity

**Does posture, wrist/elbow position, or neck/back movement trigger it?**

☐ A limb position or compression ☐ Neck or back movement ☐ No mechanical trigger ☐ Not sure

**Is there weakness, clumsiness, facial droop, or speech difficulty?**

☐ No ☐ Local hand/foot weakness ☐ Face droop, speech difficulty, or one-sided weakness ☐ Not sure

## 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.

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## Pattern 1: Sudden face or hemibody sensory change

**Which sensory map fits best?** Face and/or one whole side of the body
**How did the symptom begin?** Suddenly, over seconds or minutes

### Emergency warning pattern — Now

Sudden facial or one-sided numbness/deadness is a stroke-pathway presentation even without pain.

**Differential to review:**

- Stroke/TIA or another focal central lesion

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

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## Pattern 2: Compression-mapped focal pattern

**Which sensory map fits best?** Specific fingers or one hand / One isolated skin patch
**Does posture, wrist/elbow position, or neck/back movement trigger it?** A limb position or compression

### Structured clinical review pattern — Routine review

Position-triggered symptoms in a specific focal territory support entrapment neuropathy.

**Differential to review:**

- Entrapment or focal peripheral neuropathy

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

## Pattern 3: Root-like limb pattern

**Which sensory map fits best?** A band down one arm or leg
**Does posture, wrist/elbow position, or neck/back movement trigger it?** Neck or back movement / No mechanical trigger

### Prompt clinical review pattern — Promptly

A root-like limb distribution follows radiculopathy/plexus localization.

**Differential to review:**

- Radiculopathy or plexopathy
- Entrapment or focal peripheral neuropathy

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

## Pattern 4: Focal sensory change with motor signs

**Is there weakness, clumsiness, facial droop, or speech difficulty?** Local hand/foot weakness / Face droop, speech difficulty, or one-sided weakness

### Urgent assessment pattern — Same day

Associated motor findings increase the need for prompt structural and central/peripheral assessment.

**Differential to review:**

- Stroke/TIA or another focal central lesion
- Radiculopathy or plexopathy

**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 Stroke/TIA or another focal central lesion

**Discriminating features:** Sudden face/one-sided sensory loss, cortical symptoms, or associated weakness/speech/visual findings.

**Logical investigations:** Emergency vascular assessment for sudden onset; brain/vascular imaging based on examination.

## 3.2 Entrapment or focal peripheral neuropathy

**Discriminating features:** Specific median, ulnar, radial, peroneal, or cutaneous territory with positional/compression triggers.

**Logical investigations:** Nerve-mapped sensory/motor/reflex examination; electrodiagnostics or ultrasound for persistent, progressive, or unclear cases.

## 3.3 Radiculopathy or plexopathy

**Discriminating features:** Root-like radiation, spinal association, myotomal weakness, or reflex change.

**Logical investigations:** Root/plexus examination; MRI and electrodiagnostics selected by severity, progression, and anatomical uncertainty.

## 3.4 Central sensory, migraine, or functional sensory pattern

**Discriminating features:** Migratory/transient symptoms, headache association, non-anatomical variation, or central sensory signs require careful correlation.

**Logical investigations:** Full neurological examination; investigate based on tempo and objective signs rather than distribution alone.

## 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. (2019, updated 2023). *Suspected neurological conditions: recognition and referral (NG127)*. https://www.nice.org.uk/guidance/ng127

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**Madison Neurology LLC — Neurology Symptom Guide**
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Educational reference only. Not for clinical use. Treatment is outside the scope of this workbook.