MADISON NEUROLOGY · NEUROLOGY SYMPTOM GUIDE

Unpleasant abnormal sensations

Structured history, interpretation & clinical review

Symptom 31 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

Burning, shooting, or touch-evoked pain is mapped anatomically and by sensory signs; pain quality alone does not localize the lesion.

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 Unpleasant abnormal sensations

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 distribution best describes the pain?

☐ One localized nerve or skin area ☐ One arm or leg, possibly root-linked ☐ Both feet or both hands, length-dependent ☐ Widespread or not anatomically fixed

What happens with light touch or temperature?

☐ Normally painless touch is painful ☐ Reduced feeling in the same area ☐ Both heightened pain and reduced feeling ☐ No noticeable sensory change

Is there a plausible injury, rash, surgery, diabetes, or exposure?

☐ A shingles-like rash ☐ Surgery, trauma, or compression ☐ Diabetes, nutritional, kidney, or toxin risk ☐ No known cause

Does pain disrupt sleep or daily function?

☐ Frequent sleep disruption ☐ Major activity limitation ☐ Present but manageable ☐ 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.

Pattern 1: Focal post-injury or post-rash pain

Which distribution best describes the pain? One localized nerve or skin area
Is there a plausible injury, rash, surgery, diabetes, or exposure? A shingles-like rash / Surgery, trauma, or compression

Prompt clinical review pattern — Promptly

A focal nerve distribution with injury or rash history supports a localized neuropathic-pain mechanism.

Differential to review:

- Focal neuropathy or post-surgical/post-herpetic neuralgia

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

Pattern 2: Length-dependent neuropathic pattern

Which distribution best describes the pain? Both feet or both hands, length-dependent
What happens with light touch or temperature? Normally painless touch is painful / Reduced feeling in the same area / Both heightened pain and reduced feeling

Prompt clinical review pattern — Promptly

Bilateral length-dependent symptoms and sensory change follow a polyneuropathy/small-fiber assessment pathway.

Differential to review:

- Small-fiber or length-dependent polyneuropathy
- Radicular or central neuropathic pain

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

Pattern 3: Radicular or central pattern

Which distribution best describes the pain? One arm or leg, possibly root-linked
Are there other neurological symptoms—weakness, numbness, speech change, double vision, swallowing difficulty, or severe imbalance? Yes

Urgent assessment pattern — Same day

Limb pain with additional neurological findings requires root, cord, or central localization.

Differential to review:

- Radicular or central neuropathic pain

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

Pattern 4: Mixed or non-localizing pain

Which distribution best describes the pain? Widespread or not anatomically fixed
Are there other neurological symptoms—weakness, numbness, speech change, double vision, swallowing difficulty, or severe imbalance? No

Structured clinical review pattern — Routine review

Widespread variable pain without other reported deficits needs a structured mixed-pain and function assessment.

Differential to review:

- Nociplastic, musculoskeletal, or mixed pain

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.

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 Focal neuropathy or post-surgical/post-herpetic neuralgia

Discriminating features: A focal nerve territory, injury, scar, or shingles rash supports a peripheral mechanism.

Logical investigations: Skin and sensory examination mapped to a nerve; targeted examination or testing if weakness, progression, or atypical anatomy is present.

3.2 Radicular or central neuropathic pain

Discriminating features: Limb radiation, root signs, spinal symptoms, or central neurological signs suggest a proximal mechanism.

Logical investigations: Neurological examination with root/cord assessment; MRI or electrodiagnostic testing according to localization.

3.3 Small-fiber or length-dependent polyneuropathy

Discriminating features: Length-dependent burning with allodynia, autonomic features, or relatively preserved reflexes can suggest small-fiber involvement.

Logical investigations: Glucose/metabolic and nutritional review; electrodiagnostics assess large fibers, while selected small-fiber testing is specialist-directed.

3.4 Nociplastic, musculoskeletal, or mixed pain

Discriminating features: Widespread variable pain without a fixed neurological map may be mixed, but remains a diagnosis after appropriate examination.

Logical investigations: Function, sleep, medication, and sensory examination; investigate objective deficits or systemic clues rather than labeling from pain quality 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

Madison Neurology LLC — Neurology Symptom Guide
Unpleasant abnormal sensations — burning, crawling, electric, or hypersensitivity
Educational reference only. Not for clinical use. Treatment is outside the scope of this workbook.