

BATHROOM EMERGENCY GUIDE / BOOK 1 OF 11



The Green Book — Body Owner's Manual

Read body signals without turning them into a diagnosis or a catastrophe.

Actual emergency?

Stop reading and use the local emergency number. In the EU, call **112**. If calling is unsafe, get to a safer place or ask a trusted person to call.

What this book is for

- What is the body doing?
- What changed?
- Which book or person takes over?

What this book does

Body observation, ordinary inputs, medication context, fainting prevention, and choosing the next book.

What it hands off

Diagnosis, emergency clearance, and personal dosing.

Contents

- First 90 seconds — notice before narrating
- Signal, story, next question
- Read the signal without putting it on trial
- A one-minute body inventory
- The three-minute experiment
- Why a small room amplifies everything
- The gastrointestinal chapter you did not ask for
- Pain: communication, not a verdict
- Water, food, and temperature
- Medication and substances: make a factual list
- Feeling faint in a room made of hard surfaces
- Quick reference — the body router

Your body came without documentation, emits alerts in several incompatible formats, and occasionally schedules maintenance during a social event. This is the aftermarket manual.

It does not diagnose. It helps you describe what is happening, notice what changed, avoid making the situation worse, and decide which other book or person should take over.

First 90 seconds — notice before narrating

[body.1]

First 90-second body, room, and attention scan

[body.fig.2]

What should be observed in body, room, and attention before choosing a route?

Scan body, room, and attention

Observe three channels before choosing the route that owns the loudest problem.

1 BODY breathing · response · pain nausea · heat · dizziness What changed?	2 ROOM smoke · gas · chemicals electricity · water · exit Is the place safe?	3 ATTENTION alarm · confusion · overload repeating thought · next step Can one action fit?
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NAME ONE OBSERVATION · CHANGE ONE SAFE VARIABLE · COMPARE ONCE · CHOOSE A ROUTE

Use three channels:

1. **Body:** what is happening, where, and in which direction?
2. **Room:** what is actually present — heat, smoke, another person, a locked door, water, medication, glass, noise?
3. **Attention:** what prediction has become louder than the available facts?

That is observation, not diagnosis. The point is to stop one frightened story from impersonating the entire situation.

Signal, story, next question

[body.2]

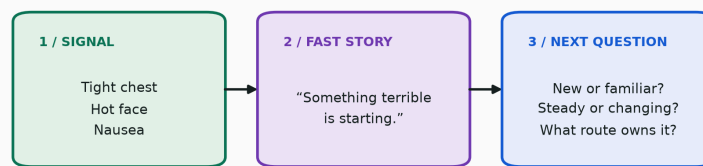
Signal, story, and next-question separation

[body.fig.3]

How can a reader separate sensation, fast interpretation, and a route-changing question?

Separate signal, story, and next question

Description keeps a difficult state observable without pretending it is harmless.



The question does not cancel danger. It decides what to check or do next.

A signal is something observable. A story is the meaning your mind attaches to it. A next question is what helps choose an action.

SIGNAL	STORY	BETTER NEXT QUESTION
heart racing	"something terrible is certain"	new or familiar; worsening or settling; any medical red flag?
someone knocked	"everyone is judging me"	do I need one sentence, more time, or an exit?
strange smell	"I must identify it"	could this be smoke, gas, electricity, or chemicals — and should I leave first?
too many tasks	"everything is equally urgent"	what prevents harm today; what can remain ugly?

Read the signal without putting it on trial

[body.3]

Symptoms and your interpretation of them arrive together, but they are not the same department. Write down the first. Stay politely suspicious of the second.

OBSERVE	USEFUL DESCRIPTION	WHAT CHANGES THE ROUTE	GO WHERE
heartbeat	fast, irregular-feeling, pounding, gradual or sudden	chest pressure, collapse, severe breathlessness, or a new severe pattern	112 for severe signs; otherwise medical advice

OBSERVE	USEFUL DESCRIPTION	WHAT CHANGES THE ROUTE	GO WHERE
breathing	comfortable, rapid, wheezing, painful, unable to finish a sentence	severe effort, blue/grey colour, swelling, choking, or rapidly worsening difficulty	112
tingling or weakness	both sides or one; moving or fixed; linked to rapid breathing or position	one-sided weakness, facial droop, speech change, sudden severe headache	112
dizziness	spinning, faint, unsteady, worse on standing	loss of consciousness, head injury, chest symptoms, neurological signs, repeated unexplained episodes	112 if consciousness was lost; otherwise prompt assessment
abdominal symptoms	location, waves or constant, stool/vomiting, food and medication context	severe localized or worsening pain, blood, rigid abdomen, persistent vomiting, collapse	112 for collapse or severe signs; otherwise urgent assessment
mental state	anxious, detached, confused, unusually sleepy	dangerous confusion, loss of reality contact, inability to remain safe	112 for immediate danger; otherwise Indigo

A familiar stress response can still deserve care. An unfamiliar symptom can still turn out to be benign. The useful distinction is not “real versus imaginary”; it is **stable versus changing, familiar versus new, and manageable versus needing another person.**

A one-minute body inventory

[body . 4]

1. Sit or lie somewhere you cannot fall from.
2. Name the loudest sensation in plain language.
3. Note when it began and whether it is improving, stable, or worsening.
4. Check the obvious context: heat, exertion, missed food, alcohol or caffeine, a new or missed medication, illness, injury, pregnancy, or a difficult event.
5. Decide whether the next step is ordinary care, the Red Book, a practice or pharmacy, **116 117**, or immediate help.

Do not turn pulse counting, oxygen readings, blood-pressure readings, or a smartwatch into a home clearance certificate. Devices provide data; they do not outvote severe symptoms.

The three-minute experiment

[body.5]

Three-minute observation protocol

[body.fig.4]

What happens at each minute of the bounded observation experiment, and when must it stop?

Three minutes of observation, not three minutes of delay

Use only when no immediate danger is apparent and the state is stable enough to compare.



When there is no immediate-danger signal, change one safe variable: sit down, reduce one noise, loosen tight clothing, drink normally if thirsty, stop staring at the mirror, or message one person. Compare **better, same, worse, or different** after a few minutes. Three minutes is an observation window, not a mandatory delay before seeking help.

Why a small room amplifies everything

[body.6]

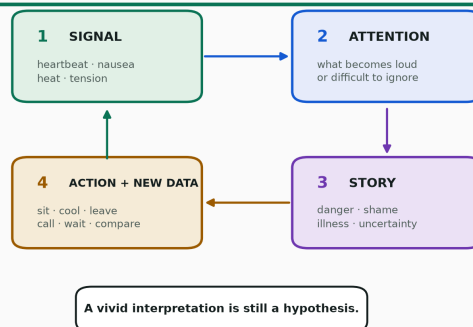
Interoception and interpretation loop

[body.fig.1]

How do signal, attention, interpretation, and action produce a revisable loop?

A body signal becomes a working hypothesis

Sensing, attention, interpretation, and action can amplify or revise one another.



Privacy removes distractions. Tile reflects sound. Mirrors recruit self-monitoring. Stress narrows attention. None of that makes symptoms imaginary; it explains why they may suddenly occupy the whole screen.

The gastrointestinal chapter you did not ask for

[body.7]

The gut and brain exchange signals continuously, so stress can change nausea, cramping, urgency, appetite, and bowel habits.¹ This is common and inconvenient. It is not a promise that every digestive symptom is stress.

While you are already here

- Lean or sit in the position that feels easiest; do not strain.

- Use ordinary, comfortable breathing rather than forced deep breaths.
- Take small normal sips when thirsty and swallowing is safe.
- Note food, travel, illness, medication, alcohol, and whether the pattern is familiar.
- Give the body time without demanding a successful bowel movement as proof of character.

Move beyond self-care when

- pain is severe, localized, or worsening;
- there is blood in vomit or stool, black stool, high fever with marked illness, a rigid abdomen, collapse, or pregnancy with severe pain, bleeding, or collapse;
- vomiting prevents fluids from staying down;
- symptoms are new, persistent, recurrent, or shrinking ordinary life.

IBS and other gut–brain disorders are real clinical conditions, not a polite way of saying “anxious stomach.” Diagnosis belongs with a clinician and an actual history, not one dramatic afternoon.²

Pain: communication, not a verdict

A 0–10 number can help describe intensity, but it does not [body . 8] measure tissue damage or urgency by itself.³⁴

Use **OPQRST**:

- **Onset**: sudden or gradual; exact time if known;
- **Provokes / palliates**: movement, breathing, food, pressure, position;
- **Quality**: pressure, burning, stabbing, cramping, aching;
- **Region / radiation**: where it begins and whether it spreads;
- **Severity**: number plus what it prevents you from doing;
- **Time**: constant, waves, recurring, improving, or worsening.

Tension and anxiety can amplify pain. A change with position, muscle relaxation, or distraction may be useful information; it does not by itself exclude a medical cause. The body is allowed to be both stressed and ill. It enjoys multitasking at inconvenient moments.

Water, food, and temperature

[body . 9]

Before constructing a grand theory, check the ordinary inputs:

- Have you eaten something familiar today?
- Have you been drinking normally for the weather and activity?
- Are you overheated, chilled, sleep-deprived, or running entirely on caffeine?
- Do you have diabetes, an eating disorder, pregnancy, kidney/heart disease, or another condition with a specific plan?

For an otherwise stable adult, ordinary food and drink may help when intake has been poor. Do not diagnose hypoglycaemia from shakiness alone, improvise salt or sugar dosing, or force fluids into someone who is drowsy, vomiting repeatedly, or at risk of choking. Follow an existing diabetes plan where applicable and seek help when the person cannot safely self-treat.

Medication and substances: make a factual list [body . 10]

Write down:

FIELD	WHAT TO RECORD
product	exact name and active ingredient if known
amount	prescribed dose and amount actually taken
timing	taken, missed, repeated, or changed when?
other substances	alcohol, caffeine, nicotine, cannabis, supplements, recreational substances
symptoms	what began before and after each exposure

Do not double a missed dose **unless the medicine's own instructions or a qualified professional tell you to**, and do not abruptly stop a prescribed medicine, restart after a long interruption, or “balance” one substance with another solely because a bathroom guide suggested confidence. Use the label, the written treatment plan, a pharmacist, prescriber, poison centre, or emergency service as appropriate.

New medication, dose changes, withdrawal, caffeine, alcohol, and other substances can all alter heart rate, sleep, nausea, balance, mood, and anxiety. That context is useful to disclose and useless to hide. Pharmacology is unimpressed by pride.

Feeling faint in a room made of hard surfaces [body . 11]

Bathrooms are excellent at hygiene and terrible at catching people.

If faintness is approaching

1. Get low immediately. Sit on the floor or lie flat; do not walk toward a more dignified location.
2. If comfortable and no injury prevents it, raise the legs slightly.
3. Move away from sharp edges and place something soft under the head.
4. Unlock the door or alert another person when safe.
5. Stay down after symptoms ease, then sit and stand in stages.

If a person becomes **unresponsive but is breathing normally**, another person should **call 112**, put them in the recovery position, and keep checking that the breathing stays normal. If they are **not breathing normally**, that is a Red Book route: **112** and start CPR. Loss of consciousness is an emergency call in its own right — “call for help” here means the emergency number, not shouting for a flatmate.⁵

A person cannot reliably manage their own future recovery position while unconscious; biology has denied that feature request.

Seek urgent assessment for

- fainting during exertion or while lying down;
- no warning, repeated episodes, pregnancy, significant injury, or slow recovery;
- chest pain, palpitations, severe breathlessness, one-sided weakness, seizure, or a known cardiac condition;

- any episode whose cause is unclear or whose consequences could be serious.

Vasovagal fainting is common and may follow heat, pain, straining, dehydration, or seeing blood, but unexplained syncope still deserves proper assessment.⁶

Quick reference — the body router

[body.12]

Where does this go?

WHAT IT LOOKS LIKE	FIRST USEFUL MOVE	THEN
familiar, stable, manageable	sit safely; describe it; change one ordinary variable; compare once	stay in Green while it stays stable
new, or getting worse	stop building a theory at home; note onset and direction	Red, 116 117 , or a clinician by severity
medication or substance uncertainty	list product, amount, time, and what changed	pharmacist, poison centre, or prescriber
feeling faint	floor first, dignity later; tell someone	assessment if unexplained or repeated
a pattern that keeps coming back	write it down instead of re-solving it nightly	planned clinical assessment
unresponsive, breathing normally	112 , recovery position, keep watching the breathing	Red / emergency services
unresponsive, not breathing normally	112 , start CPR	Red / emergency services
severe red flag	stop reading	112

If someone is unresponsive, this is no longer a Green Book problem.

Your body is not your enemy. It is a reporting system with limited vocabulary and a talent for push notifications. Give it ordinary maintenance, write down what is left, and hand the problem on when it outgrows home support.

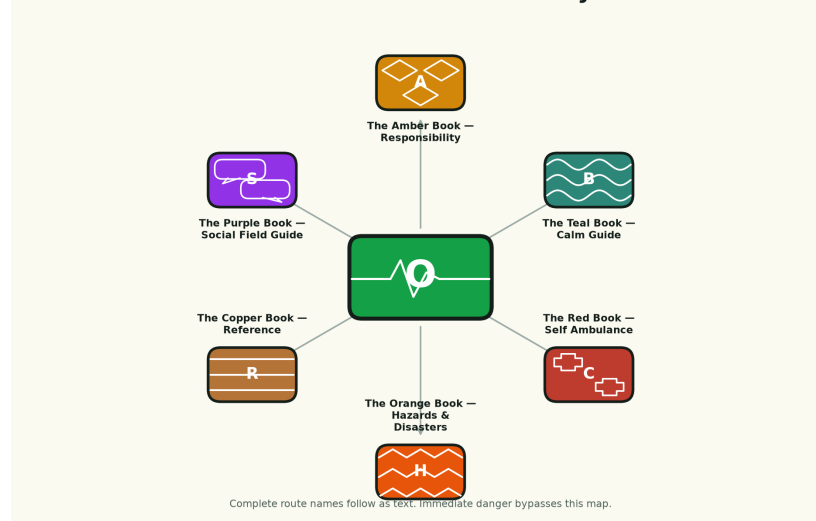
Where next?

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You do not need to complete the shelf in order. Stay here while this is the primary problem; move when another title becomes more accurate.

- **A — The Amber Book — Responsibility** — use it when that problem becomes primary.
- **B — The Teal Book — Calm Guide** — use it when that problem becomes primary.
- **C — The Red Book — Self Ambulance** — use it when that problem becomes primary.
- **H — The Orange Book — Hazards & Disasters** — use it when that problem becomes primary.
- **R — The Copper Book — Reference** — use it when that problem becomes primary.
- **S — The Purple Book — Social Field Guide** — use it when that problem becomes primary.

You are here: O — The Green Book — Body Owner's Manual



Connections from O — The Green Book — Body Owner's Manual

1. Carabotti M et al., "The gut-brain axis: interactions between enteric microbiota, central and enteric nervous systems," *Annals of Gastroenterology* 28 (2015): 203–209. <https://pmc.ncbi.nlm.nih.gov/articles/PMC4367209/>↵
2. The Rome Foundation, *Rome V: A Global Framework for Disorders of Gut-Brain Interaction*: <https://theromefoundation.org/rome-iv/rome-v/> . Rome V separates clinical from research criteria and updates the IBS and other DGBI definitions. These describe clinical patterns over time; they are not a one-visit self-diagnosis.↵
3. Raja SN, Carr DB, Cohen M, et al., "The revised International Association for the Study of Pain definition of pain: concepts, challenges, and compromises," *Pain* 161 (2020): 1976–1982. <https://doi.org/10.1097/j.pain.0000000000001939> — the paper that states and explains the current definition: pain is a personal experience influenced by biological, psychological and social factors, and is not the same thing as nociception. IASP publishes the term list itself at <https://www.iasp-pain.org/resources/terminology/> (that host refuses automated requests; confirmed by hand on 8 August 2026).↵
4. Hjermstad MJ et al., "Studies Comparing Numerical Rating Scales, Verbal Rating Scales, and Visual Analogue Scales for Assessment of Pain Intensity in Adults," *Journal of Pain and Symptom Management* 41 (2011): 1073–1093. <https://doi.org/10.1016/j.jpainsymman.2010.08.016>↵
5. gesund.bund.de, "Nummern für den Notfall": <https://gesund.bund.de/notfallnummern> . Loss of consciousness, severe breathlessness, severe chest pain or pressure and stroke signs are listed emergency examples; when it is unclear whether a situation is life-threatening, the portal advises calling 112.↵

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6. Brignole M et al., "2018 ESC Guidelines for the diagnosis and management of syncope," *European Heart Journal* 39 (2018): 1883–1948.
<https://doi.org/10.1093/eurheartj/ehy037>←