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PSYCHOLOGICAL EVALUATION

Confidentiality and the limits of confidentiality were carefully explained to the patient prior to initiating this evaluation, using language appropriate to her intellectual level. Potential risks and benefits of the evaluation were also reviewed. Mrs. Landis expressed her understanding and agreement with these concepts.

Patient: Mary Beth Landis Birthdate: 08/10/1952; Age: 72
Date of Evaluation: 07/02/25 Date of Report: 07/08/2025

Reason for Evaluation: Mary Beth Landis was referred for psychological evaluation by David Baer, MD, her primary care physician. The referral question was to ascertain the patient's current level of cognitive functioning, due to concerns about her recent decline in cognition. .

Sources of Information:

- History of psychotherapy with Mrs. Landis, from 2003 to the present
- Background Information form, completed by the patient on 6/28/03
- Telephone discussion with Dr. Baer on 5/6/25
- Psychological Evaluation report of 5/11/07, written by Wayne D'Agaro, PsyD
- Montreal Cognitive Assessment, 8.3 Edition (MoCA)
- Mattis Dementia Rating Scale, Second Edition (DRS-2)
- Trail Making Test (TMT)
- California Verbal Learning Test, Third Edition, Brief Form (CVLT3)
- Rivermead Behavioural Memory Test, Third Edition (RBMT-3), four subtests omitted
- Neuropsychological Assessment Battery Naming Test (NAB Naming)
- F-A-S Verbal Fluency Test (FAS)
- Neuropsychological Assessment Battery Auditory Comprehension Test (NAB Auditory Comprehension)
- Wechsler Adult Intelligence Scale, Fourth Edition (WAIS-IV) Comprehension subtest
- Clock Drawing Task
- Wide Range Achievement Test, Third Edition (WRAT-3)
- Beck Depression Inventory, Second Edition (BDI-II)
- Beck Anxiety Inventory (BAI)

Background Information: Mrs. Mary Beth Landis is a 72-year-old, right-handed female who lives with her husband in a private residence in Everett PA. The patient was raised together with one older sister by her divorced mother and maternal grandmother; her uncle also lived in the home. She had no contact with her father throughout her child-hood. Her mother developed dementia, presumed Alzheimer's type, in her early 70's. There is no other confirmed family history of dementia. Mrs. Landis has been married

for 38 years; she does not have children. Her support system consists of her husband and a close friend whom she has known since childhood. The patient has established her husband Keith as power of attorney (POA) for both person and estate.

Mrs. Landis completed a high school education, performing adequately academically, with no history of grade retentions or special education services. She also completed an undergraduate degree, then later master's degree, in education. Mrs. Landis worked as a first grade teacher, reading specialist, and car salesperson throughout her adult life, reporting good job performance in these positions. She retired early due to a medical disability. Since retirement, the patient has spent her time researching various topics online, doing photography, and talking by telephone daily with her closest friend. Due to severe symptoms of irritable bowel syndrome (IBS), the patient infrequently leaves the house, except to attend appointments. Mrs. Landis reported being self-sufficient in completing light housework and managing her own medical care and medications. Her husband has always managed the household finances. By her choice, she is not currently driving due to her vestibular disorder.

The patient's current medical conditions include chronic IBS and a vestibular disorder, which causes frequent problems with balance and occasional falls. She has a significant medical history of a similar dramatic decline in balance in 2016, the cause of which was never specifically identified. This balance improved over time with attendance at physical therapy. Mrs. Landis had a myocardial infarction in September of 2024. As informed by Dr. Baer, she has also had several (acutely asymptomatic) cerebrovascular accidents (CVAs) of unknown dates, as identified upon brain imaging completed in the autumn of 2024. However, recent neurological consultation did not result in a diagnosis of CVA(s). The patient has no known history of seizure disorder, head injuries, or exposure to toxic substances. Mrs. Landis has a history of mental health symptoms and treatment dating to 1989, when she first met with a psychotherapist after developing PTSD symptoms from a motor vehicle accident. She was also prescribed antidepressants by Dr. Baer. She began psychiatric care in 2003, which continues to this day, currently prescribed bupropion 450 mg qd and Alprazolam .25 mg bid. The patient has been working with me in individual psychotherapy since 2003, currently every two weeks. My working diagnoses are major depressive disorder, recurrent, currently mild severity, generalized anxiety disorder, and Cluster C personality disorder with avoidant, dependent, and obsessive traits. Mrs. Landis completed psychological testing in 2007, as part of her Office of Vocational Rehabilitation assessment when she was considering alternative employment options to accommodate her IBS symptoms. Dr. D'Agaro documented her earned Full Scale Intelligence Quotient (FSIQ) score of 109 and provided concluding diagnoses of Major depressive disorder, recurrent, moderate severity and Obsessive-compulsive personality disorder features. No cognitive deficits were identified. The patient is prescribed eight current medications and supplements for her health conditions, including the psychotropic medications listed above.

Mrs. Landis describes her mood as chronically anxious and intermittently depressed. She experiences significant and chronic sleep disturbance with initial insomnia. The patient also experiences disinterest in previously enjoyed activities, low activity levels in

general, fair self-concept, a negative worldview, and intermittent passive morbid ideation. Additionally, Mrs. Landis has chronic and excessive worry that can exacerbate her symptoms of IBS. The patient does not report or exhibit symptoms of mania, psychosis, or behavioral disturbance, and has no history of substance abuse or criminal behaviors or arrests. Identified traumatic life events including being beaten by her older sister at nights when they were children and her motor vehicle accident. She does not report typical PTSD-type symptoms from these past events, but we have hypothesized together that subconscious recall of her sister's nighttime physical attacks may be the cause of her initial insomnia.

In a telephone discussion with Dr. Baer, he expressed concerns regarding the patient's current list of complaints (see described referral problem, below). She was unable to complete a serial 7's subtraction task he provided and notably hesitated prior to stating correct orientation information.

Behavioral Observations: Mrs. Landis was punctual for her evaluation appointment, being driven by her husband. She was behaviorally cooperative throughout testing, exhibiting a mildly anxious affect with good eye contact and occasional jokes regarding testing that appeared to be anxiety-based. The patient was neatly but casually dressed and groomed and wore eyeglasses but used no other assistive devices. Mrs. Landis demonstrated clear, logical, and goal-directed speech, with no noted speech abnormalities. Her grammar and vocabulary use were consistent with her described level of academic achievement.

In describing the referral problem, Mrs. Landis reported an elementary school history of some academic struggles, including "mixing up" letters, words and numbers, stuttering, being a substandard reader, and having difficulty with left-right discrimination. She also noted she had particular difficulty in basic arithmetic using the numbers 7 and 9, which has persisted to the present day. Additionally, she reported never being able to memorize more than five pieces of information at one time (e.g. five words on a list). However, she has experienced several unusual new behaviors and experiences over the course of the last nine months, since the time of her heart attack. She again became very unbalanced last autumn, to the point of running into walls at her house and falling several times. This symptom has notably improved, but not fully resolved, since her recent attendance at physical therapy for vestibular therapy. Beginning at the end of December 2024, she saw yellow spots or blotches on white surfaces, such as her walls and countertops. These have become much less prominent but have not fully resolved. In the last several months, Mrs. Landis has noted a significant decline in her handwriting, ability to spell words, and ability to compete basic math problems, such as adding and subtracting in her checkbook. She may begin to write a simple word and use the wrong letter. The patient also described new-onset poor spatial awareness, such as missing putting her glasses on correctly, or having trouble capping a pen unless she looks directly at the pen and cap. Mrs. Landis denied difficulties remembering to take her medications, attend appointments, or where she has placed belongings. Other than infrequent word-finding difficulty, no overt behaviors indicative of memory loss or other cognitive deficit have been observed in recent therapy sessions.

During testing, Mrs. Landis demonstrated good ability to both see and hear test stimuli. She put forth good effort throughout testing, for example attempting every item presented, spontaneously guessing some responses and guessing others when so encouraged, and self-correcting two responses. The results of a measure of performance validity imbedded within the CVLT-3 corroborate Mrs. Landis's good test effort. The patient responded within an adequate time frame to known items, with no performance loss due to time delays. She accepted an offered break halfway through testing, using it to sit quietly. The patient expressed awareness of some but not all her test errors; she did not exhibit emotional distress in response to these errors. Given these observations, results of the current testing are assessed to be an accurate estimation of her current cognitive functioning.

Test Findings: See the Appendix at the end of this report for a description of tests used and this patient's specific test scores.

General Cognitive Functioning: Mrs. Landis's previously documented FSIQ of 108 places her in the average range of intelligence, consistent with her observed vocabulary and grammar usage but somewhat below what might be expected by her history of academic and work achievements. The patient's report of academic struggles in early school years also suggests that she likely put forth notable effort to achieve the academic and vocational success she has enjoyed. The current neuropsychological test results reflect a mildly clinically significant overall decline in functioning from her presumed average pre-morbid level.

Attention and Concentration: The patient performed in the average to moderately impaired range on test measures of verbal attention, including her mildly impaired performance on a simple measure of mental reaction time. It is possible that the common aversion to mental arithmetic, and her personal nemesis, the number 7, impeded her performance on a serial 7s subtraction task, where her score was moderately impaired. Although not formally scored, Mrs. Landis demonstrated mild inattention to visual detail on two of six constructional tasks presented across tests.

Memory: Current test results document Mrs. Landis's variably low average to severely impaired memory abilities. On one test, she performed notably better on delayed (as little as 30 seconds) versus immediate memory items, but on other measures, this distinction was not evident. She performed somewhat better on visually-mediated versus verbally-mediated memory tasks and on recall versus recognition memory challenges. The patient was unable to learn adequate amounts of new verbal information over repeated rehearsal trials (fewer than her self-described life-long five pieces of information). Conversely, she did learn new visual information with repetition. These test results reflect more memory impairment than she described or than I have recently observed.

Language: Current test findings reveal Mrs. Landis's variably low average to mildly impaired expressive speech, as measured on oral naming and verbal fluency tasks, respectively. However, she performed in the average range on academically-based reading and spelling tasks, the former result consistent with her performance on the

same test in 2007. The patient demonstrated moderately impaired receptive language (auditory comprehension) skills at this time. These test results reflect more language impairment than I have recently observed in therapy sessions, are partially consistent with the patient's report of recent language deficits, but are not consistent with her described spelling and writing dysfunction.

Perceptual-Motor Functioning: Mrs. Landis's perceptual-motor functioning tested as intact to low average within the present evaluation.

Arithmetic: The patient performed in the average range on a test of arithmetic, consistent with her score on the same task in 2007. This result is inconsistent with her self-report of recent difficulties performing basic math tasks.

Higher Executive Functioning: This domain assesses higher order cognitive processes. The patient exhibited average motor initiation and visual abstraction skills, and below average but intact verbal initiation, verbal abstraction, nonverbal problem solving, and social judgment. Conversely, moderate impairment was identified on a test of mental flexibility and sequencing.

Emotional Functioning: Mrs. Landis's responses to a structured self-report measure of depressive symptoms were indicative of significant current clinical depression, more intense than suggested by her clinical presentation. She endorsed severe levels of guilt, self-dislike, self-blame, disinterest, indecision, irritability, and sexual disinterest. The patient additionally endorsed moderate levels of sadness, self-perceived failure, lack of pleasure, worthlessness, low energy, and fatigue, as well as mild levels of discouragement about the future and restlessness. Her results on a structured self-report measure of anxiety similarly reflected her current experience of substantial clinical anxiety, including severe levels of inability to relax, fear of the worst happening, nervousness, fear of losing control, wobbliness in legs, unsteadiness, and abdominal discomfort. Mrs. Landis additionally reported moderate levels of feeling terrified, fear of dying, feeling scared, and dizziness or lightheadedness. Note that a number of these physiological anxiety symptoms overlap with her current vestibular disorder and ongoing IBS and may therefore have artificially elevated her score on this measure. However, the anxiety test results are consistent with both her self-report and ongoing clinical presentation.

Summary of Test Findings and Diagnostic Impressions: Results of the current evaluation reveal Mrs. Landis to be demonstrating variable cognitive abilities across domains assessed, within the context of documented average premorbid intellectual functioning. She demonstrated average to below average but intact skills in the areas of perceptual-motor functioning, mathematics, initiation, abstraction, nonverbal problem solving, and social judgment. Variably average to moderately impaired attention and average to severely impaired memory skills were identified. The patient scored in the average range on tests of written expression but the low average to mildly clinically impaired range on measures of oral expression. Moderate deficits were documented in the domains of receptive language and mental flexibility and sequencing. There were consistent test findings of the patient's differentially better performance on visually vs.

verbally-mediated test items. The current test results reflect more impairment than observed in ongoing interactions with Mrs. Landis. Compared to her self-report, test results are indicative of more severely impaired memory skills but less (i.e., none) dysfunction than she is experiencing day to day in the areas of mathematics and written expression. These neuropsychological test results, in combination with observations from our ongoing therapy relationship, support her current diagnosis of major vascular neurocognitive disorder (commonly called vascular dementia), mild impairment, in addition to her long-term psychiatric diagnoses of generalized anxiety disorder, major depressive disorder, and mixed personality disorder.

Neuropsychological testing is not intended to definitively determine the etiology of noted cognitive changes. However, a patient's medical history in combination with a particular pattern of test results can sometimes suggest likely causal factors. In this case, Mrs. Landis's medical history of documented CVAs upon brain imaging and recent vestibular disorder are strongly suggestive of a vascular basis to her dementia. Her pattern of test results, with impairment noted across cognitive domains but more verbal than visual deficits, is also most consistent with a lateralization of brain dysfunction such as occurs in vascular dementia, rather than a global dementia process such as Alzheimer's disease. Given this presumed etiology, the patient's prognosis is for stable cognition over time in the absence of additional CVAs. There is also the possibility of improving cognition over time; vascular-based cognitive deficits are known to sometimes resolve in the first one to two years post-stroke as the brain makes new neural pathways in response to ongoing mental stimulation (just as the patient has experienced improved balance in response to vestibular therapy, a type of physical stimulation).

Treatment Recommendations

1. At the patient's request and with her written permission, this report will be sent to Dr. Baer to inform his medical decision making. Mrs. Landis is scheduled to review these evaluation results and treatment recommendations with me in her next scheduled session of 7/15/25.

2. Neurological re-consultation is strongly clinically indicated in this case, to identify the need for any neurological testing, and/or assess for appropriate medical treatment(s).

3. Mrs. Landis is assessed to currently remain capable of making good life decisions. Therefore, her previously established POA should not be considered in effect at this time. Specifically, test findings document her current intermittent abilities to attend to and to recall the information needed to make important life decisions, as well as to problem-solve, think abstractly about, and make good social judgments regarding such decisions, and to initiate action upon them or effectively express them to others. However, given her documented deficits in the areas of recall (intermittently) and oral comprehension, she is advised to use compensatory strategies when acquiring information needed for important decisions, such as note-taking or recording conversations, and/or having another trusted individual with her.

4. Given the current mild overall level of Mrs. Landis's identified cognitive deficits, daily but not 24-hour supervision of her activities is clinically indicated at this time, to assure she takes medications accurately, correctly completes any prescribed medical procedures and attends scheduled medical visits, eats in a health and consistent manner, and can be assisted in emergency situations. I also advise that she put into place deliberate memory aids for any areas of significance in which she observes memory slippage (e.g., taking medications, recalling important appointments). Such aids could include cell phone reminders, timers, calendars, pill organizers, or others reminding her.

5. To promote her best cognitive as well as emotional functioning, Mrs. Landis is encouraged to be socially and behaviorally active. Many research studies have demonstrated that individuals retain their best cognitive functioning into old age if they continue to actively use these skills--in the common vernacular, "use it or lose it."

6. To facilitate her best memory functioning, the patient is advised to use multiple sources of information input, using visual and motor as well as verbal cueing strategies. That is, in addition to orally rehearsing or writing down information or procedures she wishes to recall, she may benefit from using gestures to behaviorally rehearse the information, as well as pictures to prompt recognition. For example, if she wishes to remember to take an umbrella on an outing, she might hang the umbrella on the door handle to cue herself, gesture opening an umbrella, as well as remind herself orally. Additionally, if Mrs. Landis is unable to freely recall information she wishes to attain, restructuring the information in a recognition memory (multiple choice) format may be helpful—e.g., "do I think I left my wallet in the car, on the kitchen counter, or in the bedroom?" The patient did not demonstrate upon testing the ability to effectively learn new verbal information despite repeated rehearsal trials; therefore, it is recommended to keep her life situation as stable as possible, avoiding new learning situations, and obtaining immediate instruction in novel situations, using visual learning strategies when possible.

7. The cognitive abilities most relied upon for safe driving include visual attention, reaction time, motor initiation, perceptual-motor functioning, visual abstraction, nonverbal problem solving, and mental flexibility and sequencing. Memory deficits are less relevant to driving, unless the individual forgets her destination or location and becomes emotionally distressed, therefore likely a distracted driver. Due to identification of clinical deficits in three of these specified areas (visual attention, reaction time, and mental flexibility and sequencing), it is my professional opinion that it may currently be unsafe for Mrs. Landis to drive independently. I therefore recommend that if she wishes to resume driving, she first complete and pass an on-road driving evaluation.

8. Because individuals with underlying cognitive decline are more susceptible to overlapping delirium, it is particularly important for Mrs. Landis to remain physically healthy, by such means as eating well, obtaining the best sleep possible, following doctor's orders for any current medical conditions, and accurately taking her routine medications.

9. Repeat or more extensive neuropsychological evaluation is not clinically indicated in this case unless a clear change in cognitive functioning is behaviorally demonstrated. Test results from the present evaluation will be confidentially stored at my office for ten years, should this data be needed for future comparisons. Repeated use of the MoCA could be used more frequently as a screening measure to track Mrs. Landis's estimated cognitive functioning over time in a minimally intrusive way, should this data be of interest to treating providers.

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Catherine S. Spayd, PhD, ABPP
Licensed Psychologist

Appendix

1. The Montreal Cognitive Assessment (MOCA), Version 8.3, is a brief mental status exam designed to provide a quick overview of a patient's overall cognitive functioning. On this test, education-corrected scores of less than or equal to 26/30 are indicative of impaired cognition, with lower scores representing more severe impairment.

Test: MOCA	Raw Score	Qualitative Description
	19/30	Mildly Impaired

2. The Mattis Dementia Rating Scale, Second Edition (DRS-2) is a more comprehensive measure of cognitive functioning designed to assess the presence and severity of dementia. The average peer (age- and educationally-matched) total scaled score of 10 and percentile of 50% are indicative of intact functioning. For the DRS-2 subtests, the average peer (age) scaled score of 10 and percentile of 50% are also indicative of intact functioning. The Conceptualization subtest is a measure of verbal and visual abstraction, while the Initiation/Perseveration subtest is a measure of one's cognitive ability to both initiate and appropriately curtail speech and actions.

Test: DRS-2	Raw score	Peer scaled score	Standard deviations above (+) or below (-) average	Percentile	Qualitative description of functioning
Total Score	138/144	9	0	29-40%	Below Average but Intact
Attention		11	0	60-71%	Average
Initiation/Perseveration		10	0	41-59%	Below Average but Intact
Construction		10	0	41-59%	Intact
Conceptualization		10	0	41-59%	Below Average but Intact
Memory		10	0	41-59%	Below Average but Intact

3. Trails A of the Trail Making Test (TMT) is a straightforward measure of processing speed (i.e., mental reaction time) for a brief, simple timed task. Trails B of the TMT is a complex but brief timed task of sequencing and mental flexibility. A patient's score represents her time, in seconds, to complete the task, including any time needed to correct test errors, and is compared via percentiles to age- and educationally-matched peers. The 10th percentile is the lowest percentile range provided in available test norms.

Test: TMT	Raw score (in seconds)	Percentile	Qualitative description of functioning
Trails A	80"	<10%	Mildly Impaired
Trails B	153"	<10%	Moderately Impaired

4. The California Verbal Learning Test, Third Edition, Brief Form (CVLT3) is a measure of pure verbal learning for 9 words orally presented over four immediate learning trials, with subsequent 30-second free recall, 10-minute free recall, 10-minute cued recall, and 10 minute recognition conditions. The average peer (age-matched) index score of 100 and percentile of 50% are indicative of intact functioning. A final forced-choice validity measure of the test is provided.

Test: CVLT3	Raw score	Scaled score	Index score	Standard deviations above (+) or below (-) average	Percentile	Qualitative description of functioning
Combined immediate recall trials	1, 3, 3, and 3/9		50	-3.0	<.1%	Severely Impaired
Combined delayed recall	4, 5, and 4/9		72	-1.5	3%	Mildly Impaired
10-minute recognition	7/9	7		-1.0		Mildly Impaired
10-minute recognition false positives	6	1		-3.0		Severely Impaired
Total Intrusion Errors	7	5		-1.5		Mildly Impaired
Forced-Choice Validity	9/9					Valid

5. The Rivermead Behavioural Memory Test, Third Edition (RBMT-3) includes 14 subtests measuring practical, everyday memory skills via verbally and visually/ spatially-mediated tasks. The average peer (age-matched) general memory index (GMI) score of 100 and percentile of 50% reflect intact functioning.

Test: RBMT-3	Range (or mean scaled score)	Index score	Standard deviations above (+) or below (-) average	Percentile	Qualitative description of functioning
GMI		72	-1.5	3%	Mildly Impaired
Range of Subtest Scores	5 to 13		-1.5 to +1.0		
Recall Subtests	(8.0)		-.5		Low Average
Recognition Subtests	(7.0)		-1.0		Mildly Impaired; recall > recognition
Verbal Subtests	(7.2)		-.5		Borderline Impaired
Visual Subtests	(8.4)		-.5		Low Average; visual > verbal

6. The Neuropsychological Assessment Battery Naming Test (NAB Naming) is a comprehensive evaluation of confrontational naming abilities for single-word visual stimuli. Test norms are based on a sample of peers of the same age, gender, and level of education. The average T-score of 50 is indicative of intact functioning.

Test: NAB Naming	Raw Score	T Score	Standard deviations above (+) or below (-) average	Percentile	Qualitative Description of Functioning
	29/31	44	-.5	27%	Low Average

7. The F-A-S Verbal Fluency Test (FAS) is a measure of oral fluency within a timed task. The resultant raw score is the total number of different non-proper-name words the patient can identify within one minute starting with each of the three letters F, A, and S. Test norms are based on a sample of age- and educationally-matched peers. The 10th percentile is the lowest percentile range provided in available test norms.

Test: FAS	Raw Score	Standard deviations above (+) or below (-) average	Percentile	Qualitative Description of Functioning
	24	-1.0	<10%	Mildly Impaired

8. The Neuropsychological Assessment Battery Auditory Comprehension Test (NAB Auditory Comprehension) measures understanding of oral information and commands. Test norms are based on peers of the same age, gender, and level of education. The average T-score of 50 is indicative of average functioning.

Test: NAB Auditory Comprehension	Raw Score	T Score	Standard deviations above (+) or below (-) average	Percentile	Qualitative description of functioning
	83/89	23	-2.5	<%	Moderately Impaired

9. The Wechsler Adult Intelligence Scale, Fourth Edition (WAIS-IV) Comprehension subtest is a verbally mediated measure of social judgment. The average peer (age-matched) scaled score of 10 is indicative of intact functioning.

Test: WAIS-IV	Peer scaled score	Standard deviations above (+) or below (-) average	Qualitative description of functioning
Comprehension subtest	8	-.5	Low Average

10. The Clock Drawing Task is a measure of both non-verbal problem solving and constructional abilities. The patient is orally directed to draw a clock face with a stipulated time and then subsequently is asked to copy a provided drawn clock. Drawings are scored on a scale ranging from 1 to a perfect score of 10. These scores are compared to the normative scores for a test sample of cognitively intact older adults and three test samples of older adults with various types of diagnosed dementias.

Test: Clock Drawing Task	Patient's score	Intact	Alzhei-mer's dementia	Vascular dementia	Unspeci-fied dementia	Qualitative description of functioning
Command condition-	8.5/10	9.1	4.7	3.3	5.8	Low Average
Copy condition	8/10	8.7	7.1	4.8	7.3	Low Average

11. The Beck Depression Inventory, Second Edition (BDI-II) is a self-report measure of depressive symptoms experienced over the past two weeks. On this measure, a T score of 50 is indicative of unimpaired psychological functioning when compared to a normative sample of same age peers, while T scores over 65 are considered indicative of clinical impairment.

Test: BDI-II	Raw Score	T Score	Standard devia-tions above (+) or below (-) average	Percen-tile	Qualitative description of functioning
	35	92	+4.0	99.2%	Severe Clinical Depression

12. The Beck Anxiety Inventory (BAI) is a self-report measure of anxiety symptoms experienced over the past week. On this measure, a T score of 50 is indicative of unimpaired psychological functioning when compared to a normative sample of same age peers, while scores over 65 are considered indicative of clinical impairment.

Test: BAI	Raw Score	T Score	Standard devia-tions above (+) or below (-) average	Percen-tile	Qualitative description of functioning
	29	89	-3.5	99%	Severe Clinical Anxiety

13. The Wide Range Achievement Test, Third Edition (WRAT-3), is a measure of academic functioning in the areas of Spelling, Reading, and Arithmetic. On this test, a standard score of 100 and percentile of 50% are indicative of average academic abilities when compared to a normative sample of same age peers. Scores above 130 and below 70 are indicative of superior and clinically impaired abilities, respectively. This test was provided in this case due to the patient's complaints of decline in basic academic skills. Also, it provides the opportunity to compare her scores today to what she obtained on the same test provided by Dr. D'Agaro in 2007, the only available documented baseline of this patient's cognitive abilities. Her 2007 comparative scores are noted in *(italicized parentheses).* The outdated (third edition) form was used deliberately, to make this direct comparison.

Test: WRAT-3	Raw Score	Standard Score	Standard deviations above (+) or below (-) average	Percen-tile	Qualitative description of functioning
Spelling	36	94 *(not provided)*	0	34%	Average
Reading	45	100 *(98)*	0	50% *(45%)*	Average (*Average)*
Math	35	97 *(99)*	0	42% *(47%)*	Average (*Average)*