## **Cognitive Ability Test**

CLIENT DETAILS:			
Full Name:			
Date of Birth:	Ge	ender:	
Address:			
City:	State:	ZIP:	
Contact Number:			
Email Address:			
Referring Practitioner	(if any):		
Date of Assessment: _			
BACKGROUND INFO	RMATION:		
Presenting Concerns:			
Educational History: _			
Occupational History:			
Medical History (releva	ant to cognition):		
Medications:			
COGNITIVE ASSESS	MENT AREAS:		
1. <b>Memory:</b> a. Short-Term Mem	nory:		
Task: Recall a I	ist of words after a shor	t delay.	
• Result:	out of wor	ds recalled.	
b. Long-Term Mem	ory:		
Task: Recall a I	ist of words after a longe	er delay.	
Result:	out of wor	ds recalled.	
2. Attention and Cor	ncentration:		
Task: Counting	and responding to spec	rific stimuli within a given time.	
Result:	out of corr	ect responses.	
3. Problem Solving	and Logical Reasoning	<b>j</b> :	
<ul> <li>Task: Solve puz</li> </ul>	zzles or riddles within a	time frame.	

Result: \_\_\_\_\_ out of \_\_\_\_ correctly solved.

Task: Define words, complete verbal analogies, etc.				
Result: out of correct responses.				
5. Visual-Spatial Abilities:				
Task: Interpret and analyze visual information, patterns, or shapes.				
Result: out of correct responses.				
6. Processing Speed:				
Task: Complete simple tasks under timed conditions.				
Result: Completed in minutes/seconds.				
7. Working Memory:				
Task: Manipulate and recall information within short periods.				
Result: out of correct responses.				
GENERAL OBSERVATIONS:				
INTERPRETATION:				
Based on the results, the client's cognitive abilities in the areas of appear to be				
within the percentile range, indicating a level of performance compared				
to peers.				
RECOMMENDATIONS:				
NOTES:				
Signature of Mental Health Practitioner:				
Date:				

4. Verbal Abilities: