Cognitive Ability Test

CLIENT DETAILS:

Full Name: _____

Date of Birth: _____ Gender: _____

Address: _____

City: _____ State: _____ ZIP: _____

Contact Number: _____

Email Address: _____

Referring Practitioner (if any): _____

Date of Assessment: _____

BACKGROUND INFORMATION:

Presenting Concerns:

Educational History: _____

Occupational History: _____

Medical History (relevant to cognition): _____

Medications: _____

COGNITIVE ASSESSMENT AREAS:

1. **Memory:**
   a. Short-Term Memory:
   - Task: Recall a list of words after a short delay.
   - Result: _____ out of _____ words recalled.

   b. Long-Term Memory:
   - Task: Recall a list of words after a longer delay.
   - Result: _____ out of _____ words recalled.
2. **Attention and Concentration:**
   - Task: Counting and responding to specific stimuli within a given time.
   - Result: _____ out of _____ correct responses.
3. **Problem Solving and Logical Reasoning:**
   - Task: Solve puzzles or riddles within a time frame.
   - Result: _____ out of _____ correctly solved.

4. **Verbal Abilities:**
    - 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: _____