Thought Disorder Test

Client Information:

Name:

Date of Birth:

Gender:

Address:

Phone Number:

Email Address:

Date of Consultation:

Cognitive Organization

Do you often find it challenging to organize your thoughts in a logical sequence?

Are you able to maintain coherence and clarity in your speech and writing?

Do you frequently experience difficulty in connecting ideas and expressing them coherently?

Language Expression

Do you sometimes experience word salad (incoherent speech)?

Have you ever noticed sudden interruptions or blocks in your thought flow?

Do you struggle to convey your thoughts effectively to others?

Thought Patterns

Have you noticed a tendency to jump from one unrelated topic to another during conversations?

Do you find it challenging to stay focused and maintain a consistent train of thought?

Have you experienced persistent and intrusive thoughts that interfere with your daily functioning?

Self-Reflection

Have others expressed difficulty understanding your thoughts or finding them confusing?

Do you perceive any significant changes in your thought processes compared to the past?

Have you sought professional help or been diagnosed with any mental health conditions previously?

Interpretation:

Recommendations: