

## Houston Neuropsychology Associates, PLLC

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### NEUROPSYCHOLOGICAL EVALUATION

|                                     |                                      |
|-------------------------------------|--------------------------------------|
| Name: Ricky Baker                   | Education: 11                        |
| Date of Birth (Age): 9/16/1963 (62) | Handedness: Right                    |
| Ethnicity/Race: Caucasian/White     | Occupation: Construction/Maintenance |
| Date of Evaluation: 6/29/2026       | Marital Status: Divorced             |

*This evaluation was conducted for clinical treatment planning and may not be valid for other purposes.*

**History and Presenting Problem:** The following background information was gathered from an interview with the patient and review of available medical records. Mr. Ricky Baker is a 62-year-old, right-handed, Caucasian/White male referred for neuropsychological evaluation by Marianna Karpinos, MD, secondary to concern about cognitive decline.

Mr. Baker was reportedly in his usual state of health until November 2024, when he was hospitalized at UTMB for five days due to a stroke. He was referred for speech, occupational, and physical therapies but did not participate in rehabilitation, since services were not accessible and required a lengthy drive. Mr. Baker initially required a walker for movement and experienced some falls, but he currently ambulates independently. He noted ongoing, intermittent numbness in his right hand and fingers.

Cognitively, Mr. Baker presented with concerns about a “lack of thinking.” He reported that he often stands up and forgets why he did so. He often has a hard time finding tools and misplaces items. Regarding language, he indicated that he does well discussing familiar topics; however, in routine conversation, he frequently has trouble finding words, noting that he takes longer to retrieve them. Overall, he feels that he needs to “think more” and gets frustrated when he cannot figure out what to do next.

Functionally, Mr. Baker indicated that his personal care is going “fine.” He has trouble being consistent with his medications, especially over the last month. He manages his finances without issue, as most bills are on autopay. He limits his driving to nearby areas during the daytime, noting that his depth perception is “off” secondary to cataracts.

Physically, Mr. Baker feels that his movement is “fine,” and he indicated that he occasionally climbs ladders for work. He has not had any falls. Cataract surgery is pending for September 2026. He routinely experiences tinnitus, stating, “I don’t know what quiet is.”

Emotionally, he described feeling depressed and lonely. He misses his girlfriend, who recently “ghosted” him, abruptly ending their relationship. Suicidal ideation was denied during the interview. He denied behavior suggestive of hallucinations or delusional thinking.

Regarding health habits, Mr. Baker maintains a high-protein Mediterranean diet, but noted his nutrition has worsened since his girlfriend left. He sleeps with the television volume up loud to manage his tinnitus and reported poor sleep over the last month, though it had been adequate before that time. Mr. Baker has a history of substance abuse. He reports at least 10 years of heavy drinking (12-pack per day); he has not consumed alcohol since July 2019. He also has a history of methamphetamine use but has been abstinent since 2019. He has a history of routine nicotine use but no longer smokes cigarettes; he currently vapes.

Medical & Psychiatric History: Medical history is remarkable for atrial fibrillation, liver cirrhosis, heart disease, stroke, kidney cancer, kidney disease, cataracts, tinnitus/hearing loss, and Hepatitis C.

Surgical history is notable for procedures on his left knee, right shoulder, hand/fingers related to MRSA infection (s/p fusion), oral cavity, cardiac ablation, three kidney surgeries (most recently in November 2025), and a brain catheter.

Psychiatric history is remarkable for depression and anxiety. He previously saw a psychiatrist and tried different medications, but experienced adverse side effects with each of these. He denied any previous history of psychotherapy.

Imaging (MRI Brain without contrast performed on 5/18/2026) was read to show, “1. No acute intracranial process identified. 2. Multifocal scattered chronic infarcts, with greater involvement of the left cerebral hemisphere, as described above. Moderate chronic small vessel ischemic changes. 3. Additional chronic and incidental findings described above.”

Family medical history is notable for strokes and alcoholism in his father, who passed away in his 70s. He reported that his mother is currently in good health (reported she is 75).

Medications: apixaban, atorvastatin, tadalafil, metoprolol, and tamsulosin.

Psychosocial History: Mr. Baker was born in Dallas, Texas, and lived in Kansas and Colorado. He did his schooling in Texas, completing the 11th grade and earning his GED. He denied a history of learning problems.

Mr. Baker has worked in construction and maintenance. Currently, he performs maintenance on his grandchildren's properties and mows lawns. Previously, he worked in Colorado, where he worked construction.

Mr. Baker is divorced, having been married three times. He has six biological children, several stepchildren, over 12 grandchildren, and six great-grandchildren.

Behavioral Observations: Mr. Baker presented to the appointment a few minutes late. He was unaccompanied, having driven himself. He was casually dressed and adequately groomed. He ambulated independently. Interpersonally, Mr. Baker was pleasant. He was alert and fully oriented to person, place, and time. Comprehension was grossly intact, and he followed directions as given. Spontaneous speech was fluent, though mildly tangential at times. Thought

content was logical. There was no behavioral indication of hallucinations or delusional thinking. Vision and hearing were adequate for the purposes of testing, though he noted pending cataract surgery and an ongoing history of tinnitus. Affect was euthymic and appropriate to the setting, while his self-reported mood was depressed. Rapport was established with minimal effort. With regard to test-taking style, Mr. Baker exhibited a relaxed demeanor. He was fully cooperative and completed all activities asked of him.

Results: Mr. Baker scored within expected limits on measures of task engagement/performance validity. Cognitive results are considered valid.

*Performance descriptors follow the American Academy of Clinical Neuropsychology consensus statement on uniform labeling of test scores.*

| <b>Domain</b>                       | <b>Test Name</b>               | <b>Raw Score</b>    | <b>Descriptor</b> |
|-------------------------------------|--------------------------------|---------------------|-------------------|
| Auditory Attention                  | WAIS-IV DSF                    | 12                  | High Average      |
|                                     | WAIS-IV DSB                    | 6                   | Low Average       |
|                                     | WAIS-IV DSS                    | 7                   | Average           |
| Visual Attention & Processing Speed | WAIS-IV Coding                 | 47                  | Average           |
|                                     | WAIS-IV Symbol Search          | 26; 2 errors        | Average           |
|                                     | Trail Making Test- A           | 32 seconds; 1 error | Average           |
|                                     | D-KEFS Color-Word Color Naming | 40 seconds          | Low Average       |
|                                     | D-KEFS Color-Word Word Reading | 30 seconds          | Low Average       |
| Language                            | WRAT-5 Word Reading            | 68                  | High Average      |
|                                     | NAB Naming                     | 30                  | Average           |
|                                     | Animal Naming                  | 17                  | Average           |
| Verbal Memory                       | CVLT-3 Total (6-7-10-13-11)    | 47                  | Average           |
|                                     | CVLT-3 Short Delay Free        | 13                  | Above Average     |
|                                     | Short Delay Cued               | 14                  | Above Average     |
|                                     | Long Delay Free                | 13                  | High Average      |
|                                     | Long Delay Cued                | 13                  | High Average      |
|                                     | Repetitions                    | 20                  | Below Average     |
|                                     | Intrusions                     | 0                   | Above Average     |
|                                     | Recognition Hits               | 16                  | Above Average     |
|                                     | False Positives                | 1                   | Average           |
|                                     | Recognition discrimination     | ---                 | Above Average     |
| WMS-IV                              | Logical Memory I               | 27                  | Average           |
|                                     | Logical Memory II              | 18                  | Average           |
|                                     | Retention                      | ---                 | Low Average       |

|                       |   |   |                             |
|-----------------------|---|---|-----------------------------|
|                       | Recognition                                   | 24  | Within Normal Limits        |
| Visual Memory         | Visual Reproduction I                         | 40  | High Average                |
| WMS-IV                | Visual Reproduction II                        | 33  | High Average                |
|                       | Retention                                     | ---                                       | Average                     |
|                       | Recognition                                   | 7   | Within Normal Limits        |
| Visuospatial          | WAIS-IV Matrix Reasoning                      | 18  | High Average                |
|                       | Benton JLO                                    | 29  | Above Average               |
|                       | RCFT Copy                                     | 26; methodical approach; mild imprecision | Exceptionally Low           |
| Executive Functioning | FAS   | 44  | Average                     |
|                       | Trail Making Test- B                          | 85 seconds; 2 errors                      | Average                     |
|                       | D-KEFS Color-Word Inhibition Time             | 94 seconds                                | Low Average                 |
|                       | D-KEFS Color-Word Inhibition Errors           | 1   | Average                     |
|                       | D-KEFS Color-Word Inhibition/Switching Time   | 73 seconds                                | Average                     |
|                       | D-KEFS Color-Word Inhibition/Switching Errors | 1   | High Average                |
|                       | WAIS-IV Similarities                          | 26  | Average                     |
|                       | M-WCST Categories Completed                   | 6   | High Average                |
|                       | M-WCST Perseverative Errors                   | 1   | High Average                |
| Motor                 | Grooved Pegboard- DH                          | 114 seconds                               | Below Average               |
|                       | Grooved Pegboard- NDH                         | 116 seconds                               | Below Average               |
| Self-Report           | BDI-II  | 19  | Mild symptoms of depression |
|                       | GAD-7   | 6   | Mild symptoms of anxiety    |

Impressions: Performance on the current neuropsychological evaluation is interpreted within the context of premorbid ability, which is estimated to be within the high average to average range based upon reported academic achievement and performance indicators.

Mr. Baker's cognitive test findings were broadly within expected limits, as most performances fell within the average to high average range. Specifically, performances on measures of auditory attention/working memory, visual attention/psychomotor speed, language, visuospatial reasoning, and executive functioning fell within expectation. Notably, his performances across measures of learning and memory were a significant strength; acquisition of unstructured verbal

information, story learning, and visual registration were well within or above expectation, with intact delayed recall and recognition.

He exhibited relative weakness on a task of visuospatial construction, where imprecision was likely secondary to speed as opposed to neurological dysfunction. Bilateral fine motor speed/dexterity was also slowed, which is likely an artifact of reported physical limitations, including right-hand numbness secondary to a prior stroke and a history of MRSA hand surgeries that resulted in two fingers being surgically fused.

From an emotional standpoint, he reported mild features of anxiety and depression. However, these scores contrast with his clinical interview, wherein he endorsed significant feelings of loneliness, isolation, and depression following the recent, unexplained departure of a long-term partner. He also endorsed recent struggles with insomnia.

Summary: Mr. Baker's neurocognitive profile is remarkable for multiple cognitive strengths, as performances across measures of attention, processing speed, language, learning, memory, visuospatial reasoning, and executive functioning were broadly within expectation. He exhibited isolated weaknesses in complex visuoconstruction and fine motor dexterity; however, these are likely due to intraindividual variability and physical limitations, as noted earlier, as opposed to underlying cognitive decline.

Functionally, Mr. Baker maintains his independence with basic and instrumental activities of daily living and continues to work in construction and maintenance. Mr. Baker's perceived cognitive difficulties appear heavily influenced by significant psychosocial stressors, including recent relationship loss and related mood and sleep disturbance. Nevertheless, Mr. Baker has a complex medical history, including multifocal scattered chronic infarcts, with greater involvement of the left cerebral hemisphere per imaging, as well as a significant substance abuse history that place him at greater risk for cognitive decline. However, despite these multiple compounding medical and neurological risk factors, Mr. Baker is doing exceptionally well from a neuropsychological standpoint. Although there is currently no evidence of objective cognitive decline, the possibility of this occurring in the future cannot be entirely ruled out.

Diagnosis: Cognitive Impairment Ruled Out  
Adjustment Disorder with Mixed Anxiety and Depressed Mood

Recommendations:

1. **Psychotherapy & Psychoeducation:** Mr. Baker may benefit from psychotherapy, such as cognitive-behavioral therapy (CBT) with a clinical psychologist to learn strategies to cope with distress. Psychologytoday.com is a recommended resource to locate a therapist, where in-person and telehealth options are often available. Therapy could provide a supportive space to process feelings of depression and loneliness following the unexplained departure of his recent partner. High levels of stress, grief, and poor sleep can heavily drain a person's mental energy and mimic cognitive decline, likely contributing to the everyday forgetfulness, frustration, and subjective "lack of thinking" he has been experiencing.

2. **Maintenance of Abstinence:** Mr. Baker is highly commended for his sustained sobriety from alcohol since July 2019, as well as his prolonged abstinence from illicit substances. Given his complex medical history, including a previous stroke and chronic small vessel ischemic changes, his continued abstinence is paramount for preserving his neurocognitive health and mitigating the risk of future decline. He is strongly encouraged to continue prioritizing his sobriety, particularly while navigating his current psychosocial stressors and feelings of depression.
3. **Safety & Daily Functioning:** Given his persistent right-hand numbness and history of fused fingers, Mr. Baker must exercise heightened vigilance regarding safety when utilizing ladders and power tools for his construction and maintenance work. He should also continue to limit his driving at night or in unfamiliar areas, pending his upcoming cataract removal surgery scheduled for September.
4. **Medical Management:** He is encouraged to engage in positive health behaviors to promote physical and cognitive health, including routine preventative care and adherence to his prescribed medication regimen.
5. **Sleep Hygiene:** Mr. Baker may benefit from education regarding proper sleep hygiene and healthy sleep habits to promote restful and restorative sleep and combat his recent insomnia. Useful strategies include following a regular sleep/wake schedule, developing a bedtime routine, and avoiding screen time before going to bed.
6. **Continued Use of Compensatory Strategies:** General compensatory strategies are recommended to help maximize cognitive efficiency. These may include breaking tasks down into smaller parts, having a place for everything, reducing distractions, attending to one task at a time, and using checklists/to-do lists. By implementing structure and order into his daily routine, he will likely experience greater cognitive efficiency. Mr. Baker may also find mindfulness practice helpful for connecting with the moment and enhancing attention to the “here and now”.
7. **Social and Behavioral Activation:** Mr. Baker is encouraged to routinely participate in personally meaningful activities to optimize his mood and overall well-being. Reintegrating consistent social interactions with friends and family can provide vital emotional support and a sense of purpose.

Thank you for the opportunity to participate in this patient’s care.

*Aimee Giammittorio, Ph.D.*

Licensed Psychologist

Electronically signed: 6/30/2026.