Houston Neuropsychology Associates, PLLC

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NEUROPSYCHOLOGICAL EVALUATION

Name: Anita Greensage
Date of Birth (Age): 8/14/1969 (56)
Ethnicity/Race: Hispanic/Latina
Date of Evaluation: 6/12/2026

Education: 16
Handedness: Right
Employment: Full-Time
Marital Status: Married

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. Ms. Greensage is a 56-year-old, right-handed, Hispanic/Latina female referred for neuropsychological evaluation by Shonte Byrd, MD, secondary to concern about cognitive decline.

Cognitively, Ms. Greensage reported a 10-year history of cognitive decline that initially presented as mild forgetfulness, which she attributed to “menopause brain.” However, she feels that her cognition has continued to worsen over time. Current concerns include memory loss, word-finding difficulties, and trouble processing information. She reported that her brain frequently “goes blank” or “shuts down” when overwhelmed, requiring her to take breaks to regroup. She also noted losing her train of thought mid-conversation and forgetting previous discussions entirely.

Functionally, she performs all daily tasks without issue, though notes that she easily feels overwhelmed and finds it hard to prioritize tasks. She is independent with laundry, cleaning, and cooking. She denied any problems with driving or medication management. Her husband has always handled the finances.

Physically, Ms. Greensage noted that her balance is “off,” though she has not suffered any falls. She has a history of macular degeneration diagnosed in her late 20s and wears glasses; otherwise, she describes vision as adequate. Hearing remains unchanged.

Regarding health habits, she reportedly sleeps well and experiences adequate daytime energy. She is a former nicotine user (quit before having children). She engages in occasional alcohol consumption with no history of abuse. She denied history of using recreational substances.

Emotionally, she described her mood as “super emotional” much of the time. She became tearful when speaking about her cognitive concerns during the interview. She noted that she has always been emotional, but it has increased over the last few years. She reported some anxiety in the past with no formal treatment, and no history of depression or psychosis.

Medical & Psychiatric History: Medical history is remarkable for hypertension, rheumatoid arthritis, and macular degeneration.

Surgical history is notable for a cesarean section (x4) and laparoscopy (x2) for an ovarian cyst.

Psychiatric history is unremarkable.

Family medical history is notable for rheumatoid arthritis in her 81-year-old mother, who is now experiencing memory changes. Her father had diabetes and heart disease and passed away one year ago at the age of 79; he reportedly had some memory issues. Her brother has no health issues. Her sister has rheumatoid arthritis and has a history of a stroke. There is no known family history of a formal dementia diagnosis.

Medications: hydroxychloroquine and naproxen.

Psychosocial History: Ms. Greensage was born and raised in Texas. She is a monolingual English speaker. She denied history of learning disorder or grade retention. She has a bachelor's degree in criminal justice. Vocationally, she has historically worked office jobs. For the last four years, she has been working for a medical supply company. She is married, with one prior marriage, and has a total of four children, two of whom currently live at home.

Behavioral Observations: Ms. Greensage presented to the appointment alone. She was casually dressed and adequately groomed. She ambulated independently, with unremarkable gait and motor behavior. Interpersonally, she was friendly. Comprehension was grossly intact, and spontaneous speech was clear and fluent. Thought content was logical, and there was no behavioral indication of hallucinations or delusional thinking. She was alert and fully oriented. She exhibited good eye contact. Vision (corrected) and hearing were adequate for the purposes of testing. Affect was broad and appropriate to the setting. Rapport was established with ease. With regard to test-taking style, Ms. Greensage expressed feeling unsure of herself and became tearful at times. She understood task instructions as provided and worked at a consistent pace.

Tests Administered:
Standalone and Embedded Measures of Task Engagement
Wide Range Achievement Test- Fifth Edition, Reading Subtest
Wechsler Adult Intelligence Scale- Fourth Edition, Select Subtests
Wechsler Memory Scale- Fourth Edition, Select Subtests
California Verbal Learning Test- Third Edition
Rey Complex Figure Test Copy
Judgment of Line Orientation
Delis-Kaplan Executive Function System Color-Word Interference Test
Modified Wisconsin Card Sort Test
Phonemic and Semantic Fluency
Trail Making Test- A & B
NAB Naming
Grooved Pegboard
Generalized Anxiety Disorder-7

Beck Depression Inventory- II
Minnesota Multiphasic Personality Inventory-2—Restructured Form

Results: On standalone and embedded measures of task engagement/performance validity, the patient's performance was mixed, including below recommended clinical cutoffs on select measures. The results are believed to serve as an underestimate of her current neuropsychological status and limited interpretation is provided.

Summary & Impressions: Ms. Greensage was referred for this evaluation due to concern about cognitive decline. During the current evaluation, Ms. Greensage's performances on a standalone measure of task engagement and performance validity fell below clinical expectations. Consequently, the obtained cognitive data represent an invalid estimate of her true neuropsychological baseline, precluding the reliable attribution of her test scores to a primary neurologic etiology.

Within the context of this invalid presentation, her performance on several measures assessing language, visual attention and processing speed, visuospatial functioning, verbal and visual learning/memory, and higher-order cognitive skills remained largely intact. Specifically, she scored within normal limits on single word reading, verbal concept formation, confrontation naming, phonemic fluency, and rapid color naming and word reading. Digit repetition and reversal, speeded symbol/digit transposition, nonverbal reasoning, judgment of angular line relations, and cognitive set-shifting and complex response inhibition were also within expectation. Visual learning and memory were within expected limits, as well as verbal learning (structured and unstructured), immediate word list recall, and recognition memory for unstructured verbal information. Other performances, however, fell below expectation to varying degrees.

From an emotional standpoint, she endorsed mildly elevated symptoms of anxiety and depression on a mood questionnaire, including multiple physical concerns. On a personality inventory, she exhibited a tendency to underreport minor faults and shortcomings that most individuals acknowledge, presenting herself in a positive light. Within this context, her responses were consistent with individuals who report heightened somatic complaints, including head pain, vague neurological concerns, diffuse pattern of cognitive difficulties, and a general sense of malaise manifested in poor health. Individuals with similar profiles report history of suicidal ideation, self-doubt, and heightened stress and worry.

While an underlying neurocognitive process cannot be definitively ruled out, the lack of valid data precludes the formal identification of a neurocognitive disorder at this time. Instead, her clinical presentation is strongly indicative of cognitive inefficiency driven by psychological factors. She reported significant subjective distress, and she was notably tearful during the clinical interview. It is highly likely that her emotional reactivity, feelings of being overwhelmed, and suboptimal test engagement are the primary drivers of her current cognitive complaints and her varied testing performance.

Diagnosis: Cognitive Inefficiency, Likely Due to Non-Neurological Factors
Generalized Anxiety Disorder

Recommendations:

1. **Psychotherapy:** Ms. Greensage is strongly encouraged to engage in individual, evidence-based psychotherapy, such as cognitive-behavioral therapy (CBT) to help her develop effective coping strategies for managing heightened psychological distress and subjective cognitive changes.

2. **Compensatory Cognitive Strategies:** To assist with multitasking at work and home, she should utilize external organizational aids. Useful strategies include utilizing written checklists, breaking complex tasks into smaller manageable steps, reducing environmental distractions, and prioritizing tasks one at a time.

3. **Mindfulness and Stress Reduction:** Incorporating daily mindfulness practices and stress-reduction techniques is recommended. Grounding her attention in the present moment may help mitigate the cognitive "blanking" or "shutting down" she experiences when she feels overloaded with information.

4. **Medical Coordination:** Continued regular follow-up with her primary care physician and rheumatologist is advised. Careful management of her systemic health conditions, including her hypertension, macular degeneration, and rheumatoid arthritis, is essential, as these can broadly impact daytime energy and cognitive efficiency.

5. **Health and Lifestyle:** She is encouraged to engage in positive health behaviors to promote physical and cognitive health. This includes maintaining a well-balanced diet, engaging in regular physical activity as tolerated, ensuring adequate sleep hygiene, and prioritizing routine social engagement to optimize her overall well-being.

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

Aimee Giammittorio, Ph.D.
Licensed Psychologist

Electronically signed: 6/15/2026.