Houston Neuropsychology Associates, PLLC

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NEUROPSYCHOLOGICAL EVALUATION

Name: Joan Halliday
Date of Birth (Age): 3/18/1947 (79)
Ethnicity/Race: Caucasian/White
Date of Evaluation: 6/12/2026

Education: 16
Handedness: Right
Occupation: Retired
Marital Status: Widowed

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 her son-in-law, as well as a review of available medical records. Ms. Joan Halliday is a 79-year-old, right-handed, Caucasian/White female referred for neuropsychological evaluation by Barbara Robinson, NP, secondary to concerns about cognitive decline. MMSE was 28/30 on 4/2/2026.

Cognitively, Ms. Halliday feels like she is losing memories for things she knows well; however, she was unable to provide examples, despite being provided with several during the interview session. She ultimately stated that she is having word-finding issues. Her son-in-law reported that she confused her son with her husband in February 2026, with a few instances occurring at that time. He suspects these issues began four to five months ago, without any clear precipitating event. Ms. Halliday moved into a senior living facility two months ago, which she described as a a difficult transition. She and her family are in the process of getting her home ready for sale.

Emotionally, Ms. Halliday describes her mood as “pretty good.” She misses her house but is not feeling depressed or anxious, remarking that she “always gets up and gets dressed.” She denied experiencing behavior suggestive of hallucinations or delusions.

Functionally, Ms. Halliday maintains her own apartment. Although housekeeping services are available, she denied any issue with independently maintaining the cleanliness of her apartment or doing her laundry. She makes sandwiches and uses the microwave in her apartment without issue; there is a dining area on the premises for meals. Her daughter fills her medication organizer each week, and the patient reportedly takes her medications as indicated. Her son has handled most of her finances for the last two months. Similarly, she stopped driving two months ago due to her son’s fear of her getting lost, though she denied this had happened.

Regarding sensory function, her vision is corrected with glasses; cataracts are being monitored, but she reportedly sees well for reading. She has diminished hearing and needs bilateral hearing aids.

Physically, she reports no changes to movement or balance and denied any history of falls.

Regarding health habits, she sleeps well from 10:00 PM to 8:00 AM. She has a good appetite and eats well. She has never used nicotine or illicit substances. She previously consumed alcohol but has no history of abuse.

Medical & Psychiatric History: Ms. Halliday's medical history is remarkable for hypertension, cardiac arrhythmia, breast cancer (s/p lumpectomy), hypothyroidism, hearing loss, and cataracts. She also has an aortic aneurysm that is being monitored.

Surgical history is notable for a lumpectomy. Psychiatric history is unremarkable.

A CT Brain (performed on 3/10/2026) was read to show, "No CT evidence of acute intracranial abnormality or hemorrhage…There are low attenuation regions within the periventricular white matter, this is nonspecific, most commonly associated with microvascular ischemic changes."

MRI Brain (performed on 3/16/2026) was read to show, "Minimal patchy areas of abnormal hyperintense signal intensity in the white matter suggesting findings of minimal chronic small vessel ischemic changes."

Family medical history is unclear. Her mother passed away at age 92. Her father passed away at age 70. She has an identical twin who is very healthy.

Medications: alendronate, vitamin D, carvedilol, fenofibric acid, losartan, nifedipine, pravastatin, omeprazole, hydralazine, levothyroxine.

Psychosocial History: Ms. Halliday was born and raised in Michigan. She is a monolingual English speaker. She denied history of learning disorder or grade retention. She obtained a bachelor's degree and worked as a teacher for one year before marrying and starting a family. She last worked at the public library for 20 years. She retired 10 years ago.

Ms. Halliday has three children and one grandchild. She has been widowed for 8 years.

In her leisure time, she enjoys watching television. She used to enjoy reading but no longer engages in this activity.

Behavioral Observations: Ms. Halliday presented to the appointment on time, accompanied by her son-in-law. She was casually dressed and adequately groomed. She ambulated independently. Interpersonally, she was pleasant. Affect was flat. Her comprehension was grossly intact. She was partially oriented to place, initially noting that she was in Michigan but quickly self-correcting that she was in Houston. Spontaneous speech was sparse, and her responses were brief, so it was challenging to get a sample of her speech patterns. During the testing session, she exhibited anomia and paraphasic errors, and she was self-critical of her performance on language measures (e.g., verbal fluency and verbal abstract reasoning). She was alert and fully oriented to person and time. Vision (corrected) and hearing were adequate for the purposes of testing.

With regard to her test-taking style, Ms. Halliday was easily engaged. However, she appeared to fatigue as the session progressed. She frequently required repetition of task instructions, especially as the activities increased in complexity. She generally worked slowly. During visuospatial and novel problem-solving activities, she experienced significant frustration and anxiety, remarking, "I always hated art" and "I can't do this," ultimately resulting in the premature discontinuation of several complex measures. Despite these challenges, she remained pleasant and cooperative.

Results: Ms. Halliday 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.

Domain	**Test Name**	**Raw Score**	**Descriptor**
Auditory Attention	WAIS-IV DSF	11	High Average
	WAIS-IV DSB	6	Average
	WAIS-IV DSS	1	Exceptionally Low
Visual Attention & Processing Speed	WAIS-IV Coding	19	Below Average
	WAIS-IV Symbol Search	5; 1 error	Exceptionally Low
	Trail Making Test- A	206 seconds	Exceptionally Low
Language	WRAT-5 Word Reading	55	Average
	WAIS-IV Vocabulary	23	Low Average
	NAB Naming	15	Exceptionally Low
	Animal Naming	7	Exceptionally Low
Verbal Memory	HVLT-R Total Recall (2-5-5)	12	Exceptionally Low
	Delayed Recall	3	Below Average
	% Retained	60%	Low Average
	Recognition Hits	10	---
	False Positives	2	---
	Recognition Discrimination	---	Low Average
WMS-IV	Logical Memory I	23	Average
	Logical Memory II	17	Average
	Retention	---	High Average
	Recognition	18	Within Normal Limits
Visual Memory	Visual Reproduction I	16	Below Average
WMS-IV	Visual Reproduction II	4	Below Average
	Retention	---	Low Average
	Recognition	3	Within Normal Limits

Visuospatial	WAIS-IV Matrix Reasoning	6	Low Average
	Benton Judgment of Line Orientation	13	Below Average
	RCFT Copy	Discontinued after 5 minutes; one element complete	---
	CLOX-2	12	Below Average
Executive Functioning	WAIS-IV Similarities	12	Below Average
	FAS	8	Exceptionally Low
	Trail Making Test- B	Discontinued at 300 seconds; 4 errors; task incomplete	---
	M-WCST	Discontinued due to reported frustration; 2 categories established	---
	CLOX-1	12	Within Normal Limits
Motor	Grooved Pegboard- DH	Discontinued at 166 seconds; task incomplete	Exceptionally Low
	Grooved Pegboard- NDH	193 seconds	Exceptionally Low
Self-Report	BDI-II	8	Minimal symptoms of depression
	GAD-7	2	Within Normal Limits

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

Ms. Halliday scored within the average to high average range on measures of simple auditory attention (digit repetition and reversal). However, complex auditory sequencing fell into the exceptionally low range.

Performances across measures of visual attention and processing speed were significantly reduced, falling within the below average to exceptionally low range.

Single-word reading was average, and expressive vocabulary was low average. In contrast, verbal fluency (phonemic and semantic) and confrontation naming were exceptionally low.

Learning and memory for structured, contextual information (stories) was intact and fell within the average range, with high average retention of the learned material. Acquisition of an unstructured list of words was exceptionally low, with below average delayed recall; however, recognition discrimination was in the low average range. Registration and retrieval of complex

visual information was below average, though recognition of visual designs was within normal limits.

Visuospatial reasoning fell in the low average range, while judgment of line orientation was below average.

While spontaneous clock draw was adequate, she struggled significantly with copying a complex figure; this activity was prematurely discontinued after five minutes with only one element completed.

Her performance on an abstract verbal reasoning task was below average. She demonstrated prominent weakness on tasks requiring cognitive flexibility and novel problem-solving, opting to prematurely discontinue these activities due to increasing frustration.

Fine motor dexterity was significantly slowed; she was unable to complete this task in her dominant, right hand.

From an emotional standpoint, she endorsed subclinical symptoms of depression on a self-report measure.

Summary: Ms. Halliday's neurocognitive profile is significant for decline as compared to her estimated premorbid baseline and the performance of same-age peers. While she maintains intact simple auditory attention, single-word reading, expressive vocabulary, and contextual verbal learning and memory, she exhibits pronounced deficits across several other domains. Specifically, her performances were significantly reduced on measures of complex auditory sequencing, unstructured verbal learning, and visual learning and memory. She also demonstrated prominent weaknesses in confrontation naming, verbal fluency, visual attention and processing speed, visuospatial perception, and complex visuospatial planning and construction. Furthermore, she exhibited significant difficulty on activities requiring executive functioning (i.e., cognitive flexibility and novel problem-solving), which were prematurely discontinued due to increasing frustration. Bilateral motor speed/dexterity was reduced.

Functionally, this cognitive profile aligns with her family's reports of progressive cognitive decline over the last few months with an associated loss of independence with instrumental activities of daily living, such as financial management and driving. Integrating her clinical history, objective test results, and reported functional decline, a diagnosis of mild dementia is warranted. The etiology of her cognitive decline appears multifaceted, consistent with a mixed vascular and Alzheimer's disease presentation. Specifically, her vascular risk burden and neuroimaging confirming chronic microvascular ischemic changes likely drive her profound deficits in processing speed and executive functioning. A superimposed Alzheimer's disease process is also suspected given her profound naming, word-finding deficits, and weakness in visuospatial functioning.

Diagnosis: Dementia Due to Multiple Etiologies, Mild Severity, With Behavioral Disturbance (Depressed Mood/Adjustment-Related Concerns)

Recommendations:

1. **Safety and Supervision:** Considering the degree of cognitive impairment, Ms. Halliday should receive continued support and oversight with basic and instrumental activities of daily living to optimize her safety and well-being. Her son is advised to continue managing her financial affairs. While her daughter currently sets up her medication caddy weekly, direct supervision of medication administration may become necessary to prevent dangerous dosing errors. Additionally, supervision when using potentially dangerous household appliances is prudent.

2. **Driving Cessation:** Ms. Halliday stopped driving two months ago at the urging of her family. Given her exceptionally low processing speed, pronounced executive dysfunction, and significant visuospatial weaknesses, permanent driving cessation is strongly advised to ensure her personal safety and the safety of those around her.

3. **Sensory Accommodations:** Ms. Halliday exhibited severe difficulties with complex visuospatial construction and judgment of line orientation. While these deficits are largely attributed to cognitive decline, she also has a history of cataracts. A comprehensive vision evaluation with an ophthalmologist or optometrist is highly recommended to rule out or treat any compounding peripheral visual acuity issues. Furthermore, because she has diminished hearing and requires bilateral hearing aids, she should follow-up with securing these devices.

4. **Medical Follow-Up:** Strict management of her cerebrovascular and metabolic risk factors (e.g., hypertension, hyperlipidemia) by her primary care provider is advised to help prevent further vascular-related cognitive decline.

5. **Compensatory Strategies:** Ms. Halliday demonstrated low frustration tolerance on complex tasks, opting to prematurely discontinue several activities. To maximize cognitive efficiency and minimize distress, tasks should be broken down into manageable, single steps. Her family should continue to utilize external aids, such as her weekly medication caddy, and implement predictable daily routines. Family members should use brief instruction, provide repetition often, and avoid delivering complex strings of information verbally.

6. **Social Engagement:** Ms. Halliday recently moved to a senior living facility and has had a difficult time transitioning, noting she has not made new friends. She is strongly encouraged to routinely participate in the games, exercises, and social activities offered on-site. Engaging in these structured, personally meaningful activities can help her build new friendships, optimize her mood, and improve her overall well-being.

7. **Future Planning:** The current findings should serve as an impetus to ensure her long-term affairs are in order. If not already completed, establishing or updating legal documentation—including a durable power of attorney for health care and financial matters, as well as an advanced care plan—is highly prudent.

8. **Caregiver Support:** Caring for a loved one with progressive dementia and behavioral disturbances is highly demanding. Her family is strongly encouraged to engage in routine

self-care to prevent caregiver burnout. The Alzheimer's Association (www.alz.org or 713-314-1313) is an excellent resource for education, care planning, and emotional support.

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

Aimee Giammittorio, Ph.D.
Licensed Psychologist

Electronically signed: 6/15/2026.