Neuropsychological Evaluation

NAME:	Pedro Olivares	**GENDER:**	Male
DATE OF BIRTH:	02/23/1949 (77)	**HANDEDNESS:**	LEFT
DATE OF EXAM:	06/03/2026	**ETHNICITY:**	Hispanic
EDUCATION:	20	**MARITAL STATUS:**	Married
OCCUPATION:	Retired	**REFERRED BY:**	Alix Halter, FNP-C

REASON FOR REFERRAL

Mr. Olivares was referred for evaluation of cognitive functioning due to suspected cognitive decline. Results will elucidate his current level of cognitive, emotional, and behavioral functioning to inform diagnostic decision-making and treatment planning.

PRESENTING PROBLEMS

Mr. Olivares presented with complaints of cognitive difficulties, specifically reporting that he feels more forgetful of tasks he needs to complete, occasionally forgets dates or appointments, and has difficulty learning and retaining new information. He also noted that he forgets his intentions upon entering a room and experiences difficulty paying attention due to preoccupations and obsessions regarding the news from Venezuela and his business. The patient has a long history of a head tremor that began in 2007 following the death of his son. Around 2022, he developed a resting tremor, increased rigidity, general slowness (most prominent on the right side), and significant gait changes leading to frequent falls. While medical records indicated a left-hand tremor, his wife clarified during the clinical interview that the tremor is in his right hand. He was officially diagnosed with Parkinson's disease approximately three months prior to this evaluation.

His wife, Ms. Zuleima Olivares, accompanied him and reported noticing subtle cognitive declines beginning around 2021 that have progressively worsened. She noted declines in both short- and long-term memory, observing that he forgets conversations, repeats the same questions, and recently failed to recognize a close niece. She indicated that he has difficulty sustaining attention, requires multiple readings to retain new information, and exhibits reduced problem-solving and decision-making abilities. For example, she noted he is slower when completing transportation reports for his business in Venezuela because he becomes anxious about perfecting them. Ms. Olivares also reported that she frequently has to remind him of the names of the people he is speaking with, and he has become increasingly dependent on her.

Emotionally, Mr. Olivares has a history of anxiety and depression, with symptoms first diagnosed 15 to 20 years ago. He reported feeling sad, tearful, and increasingly irritable, which he attributes to professional stressors and unresolved anger following the death of his son. His anxiety has increased; he described having worries that become obsessions, and his wife noted that he has a fear of staying home alone. He reported difficulties initiating and maintaining sleep, averaging five to six hours per night, which is exacerbated by his compulsion to watch the news. While he takes Olanzapine, which provides some benefit, his sleep remains disturbed. His wife added that he sleeps significantly during the day and previously experienced frequent nightmares

involving talking, arguing, and physically acting out before starting Olanzapine prior to the pandemic. He reported his energy and appetite as adequate. Regarding psychotic symptoms, while medical records state he denies hallucinations or bizarre behavior, his wife reported during the interview that he occasionally hears strange noises, which may be related to his hearing loss. She also described an increase in paranoia and delusions since 2021, noting he frequently believes they are being followed by a car or watched by strangers.

Functionally, Mr. Olivares ambulates independently but utilizes a pillow when sitting due to coccyx pain from a recent fall. Regarding instrumental activities of daily living, he stopped driving in November 2025 following his fall. Prior to the accident, his wife noticed he was increasingly getting disoriented while driving in familiar areas, starting in the past year. Ms. Olivares has always managed the household finances. Though Mr. Olivares feels capable of making small purchases, his wife noted she is always present during these transactions. He is reliant on his wife to schedule medical appointments in the United States, though he manages them independently when traveling to Venezuela. A clinical discrepancy was noted regarding medication management: while Mr. Olivares reported taking his medications consistently, his wife indicated he is unreliable, leading her to organize and dispense his pills using a pillbox to ensure compliance. Medical records also noted poor adherence to his Carbidopa-Levodopa regimen due to fatigue.

MEDICAL HISTORY

Conditions: Mr. Olivares's medical history is significant for atrial flutter/fibrillation (since 2017), hyperuricemia, Parkinson's disease with associated tremors, low blood pressure (hypotension), insulin resistance, cataracts, cardiac arrhythmias, hearing loss requiring hearing aids, ankylosing spondylitis, and a recent L1-L2 transverse process fracture and coccyx fracture resulting from a fall down stairs in November 2025.

Surgeries: Bilateral cataract surgery.

Imaging: An MRI of the brain completed on January 12, 2024, demonstrated moderate chronic microvascular ischemic changes and mild diffuse cerebral atrophy, with no acute intracranial abnormality. A CT of the brain completed on November 11, 2025, was negative for acute infarct or hemorrhage.

Current medications: His current medication regimen includes Allopurinol (100 mg), Amiodarone (200 mg), Carbidopa-Levodopa (25-100 mg), Sertraline HCl, Gabapentin, Rivaroxaban/Xarelto (15 mg), Esomeprazole (40 mg), Rosuvastatin (40 mg), Metformin HCl (500 mg), Cholecalciferol/Vitamin D3 (25-50 mcg), Magnesium Glycinate (360 mg), Omega-3 Fatty Acids (1200 mg), Prednisone (10 mg), and Olanzapine. It was noted that while his medical record lists Sertraline at 50 mg, his wife reported during the interview that he takes two 100 mg tablets (200 mg total) in the late afternoon.

Substance use: Mr. Olivares has never used alcohol, tobacco/nicotine, or illicit drugs.

Family history: His family history is notable for Alzheimer's disease in his mother, who was diagnosed in her late 70s and is now deceased. His father died of respiratory arrest, a brother has COPD, and a maternal aunt had a stroke.

MENTAL HEALTH HISTORY

Mr. Olivares has a documented history of anxiety and depression, with symptoms first presenting 15 to 20 years ago. He remained unmedicated until approximately five years ago, and his pharmacological dosages have increased over the last year. He is currently engaged in outpatient mental health treatment, seeing a psychiatrist once a month (for the past four months) and participating in psychological therapy every two weeks (for the past two months). He denied a history of psychiatric hospitalizations, substance abuse issues, or suicidality.

EDUCATIONAL HISTORY

Mr. Olivares completed 20 years of education. He is an attorney in public law, having earned a Bachelor's degree in Venezuela and two Doctorate degrees (one in Law and one in Transportation Management) from La Sorbonne in Paris. He denied a history of grade retention or learning difficulties. Linguistically, his primary and dominant language is Spanish. He is also fluent in French, which he uses to read and watch television, as well as Portuguese. He understands English but rarely speaks it.

OCCUPATIONAL HISTORY

Mr. Olivares is currently retired. He previously worked extensively as a professional consultant and urban transportation specialist for mass transit systems in Latin America. He also owns a preschool business in Venezuela.

SOCIAL HISTORY

Mr. Olivares was born and raised in Venezuela and immigrated to the United States on July 4, 1998, though he continues to travel back and forth frequently. He has been married to his wife, Zuleima, for 54 years. They have one living son who actively participates in his medical care, and one daughter. Another son tragically passed away in a motor vehicle collision with a drunk driver in 2007. Mr. Olivares and his wife currently reside in Houston, Texas.

BEHAVIORAL OBSERVATIONS

Mr. Olivares presented as an adequately groomed man. He was alert and fully oriented to person, place, and time. His gait was unassisted, though the examiner noted the presence of head tremors. Vision (with corrective lenses) and hearing appeared normal and adequate for testing purposes. His speech was within normal limits, and his mood was described as pleasant.

Overall, Mr. Olivares demonstrated full cooperation and maintained normal attention and concentration throughout the evaluation. The examiner noted, however, that he required simplified test instructions and occasional reminders. It was also documented that he repeatedly asked for the correct answers after completing each test. Despite these behavioral observations, he appeared to put forth his best effort. Thus, the results from this evaluation appear to provide an accurate representation of his current level of neuropsychological functioning.

TESTS ADMINISTERED

Escala de Inteligencia de Wechsler para Adultos-IV (select subtests)
Ponton-Satz Boston Naming Test
Semantic Fluency (Animales)
Lexical Fluency (PMR)
Line Orientation (RBANS)
Golden Stroop
Symbol Digit Modality Test (Motor)
WHO-UCLA Auditory Verbal Learning Test
Trail Making Test
Logical Memory I and II (WMS-IV Spanish)
Brief Test of Attention
Rey Complex Figure Test
Modified Wisconsin Card Sorting Test
Finger Tapping Test
Escala de Aculturación Bidimensional
Escala de Dominancia Bilingüe
Geriatric Depression Scale-SF (Spanish)
Generalized Anxiety Disorder (GAD-7) (Spanish)

TEST RESULTS

The patient was interviewed in Spanish by a bilingual Neuropsychologist. A bilingual technician administered all objective tests in Spanish. The patient's cultural background (e.g., Spanish first language, born and raised in Venezuela, level of acculturation, and level of educational attainment) was taken into consideration in interpreting his performance on the neuropsychological evaluation. Whenever possible, measures that have been developed and normed for Spanish-speaking individuals were utilized. If not available, the best available norms were used. With this caveat in mind, the major findings with respect to Mr. Olivares's neurocognitive functioning are summarized below.

Acculturation and Language Dominance: Measures of bilingual dominance and bidirectional acculturation reveal that the patient is definitively dominant in the Spanish language, which he acquired during early childhood, compared to his secondary acquisition of English during later childhood. Consistent with this developmental trajectory, he indicated a definitive preference to retain Spanish if hypothetically restricted to using only a single language for the remainder of his life. His bidirectional acculturation profile reflects a strong orientation toward Hispanic culture, with Spanish serving as his primary linguistic medium across all daily functional domains, including internal cognitive processes, interpersonal social communication, and general media consumption. Conversely, his functional proficiency, frequency of use, and overall comfort with English as a secondary language remain notably limited across these same domains. Ultimately, these cultural and linguistic findings confirm his primary language status and clinically justify the utilization of Spanish for the administration of this neuropsychological evaluation.

Attention/Processing Speed: On a test of sustained attention, he performed in the below average range. Graphomotor speed was exceptionally low. Speeded word reading was exceptionally low and speeded color naming was below average.

Language: Visual object naming was in the average range. Lexical and semantic fluency were both in the exceptionally low range.

Visuospatial/Constructional: His ability to copy a complex figure was high average. Visuospatial judgment was low average. On the command condition of the Clock Drawing Test, the patient produced an intact circular contour but demonstrated abnormal spatial distribution of

the numbers, relying heavily on a concrete "spoke" or "pie-slice" scaffolding rather than normative circumferential placement. When provided with a visual model in the copy condition, these spatial anomalies completely resolved, resulting in a standard, well-distributed placement of numbers along the perimeter. This marked improvement suggests that the patient's initial spatial errors were driven by a secondary organizational issue rather than a primary visuospatial constructional vulnerability.

Learning and Memory: Immediate recall of unstructured verbal material (15-word list) was in the below average range after five consecutive trials (4, 8, 6, 9, and 8 words, respectively). Immediate recall of the original list, following a distracter list, was exceptionally low (4/15 words recalled). After a 20-minute delay, his recall was exceptionally low (2/15 words recalled). Delayed word recognition was exceptionally low as he recalled 10/15 target words, and he also endorsed three false positive errors.

Immediate recall of structured verbal material (stories) was in the below average range. Delayed recall of the same material was nil and below average. On a discrimination task, his performance was in the average range.

Short (3-minute) delayed incidental recall of a complex geometric design was exceptionally low. Long (30-minute) delayed incidental recall of the same design was also in the exceptionally low range.

Executive Functions: Visual speeded sequencing of numbers was exceptionally low. He could not complete a complex sequencing (alternating number-color) as he ran out of the allotted time. His performance on a task of color-word interference was exceptionally low. Verbal abstract reasoning was in the high average range. On a complex trial-and-error learning task requiring the utilization of feedback to generate problem-solving strategies, his overall standard score fell within the low average range. However, this score belies significant executive dysfunction. Qualitatively, he was unable to complete a single category out of a possible six. Furthermore, he committed 45 total errors (below average), with nearly half (22 errors) being perseverative in nature. This high rate of perseveration falls in the exceptionally low range, highlighting pronounced cognitive rigidity and an inability to shift problem-solving sets when presented with negative feedback. In the free-draw condition, the patient showed poor executive planning by drawing "spoke" lines to place the numbers and making both hands the same length. However, when provided with a visual model to copy, they corrected all of these errors. This complete improvement shows that the patient struggles with the organization and planning needed to draw from memory, rather than having forgotten what a clock looks like.

Motor Abilities: The patient is left hand dominant. Fine motor dexterity was below average bilaterally.

Emotional/Behavioral Functioning: Mr. Olivares endorsed mild symptoms of depression on a self-report inventory of mood. He also endorsed moderate anxiety symptoms on a separate self-report inventory of mood.

SUMMARY

Mr. Pedro Olivares is a 77-year-old, left-handed Hispanic male with 20 years of formal education who was referred for a neuropsychological evaluation by Alix Halter, FNP-C, to assess cognitive decline and suspected Parkinsonism. The patient and his wife reported progressive cognitive changes beginning around 2021, characterized by increased forgetfulness, reduced attention, and difficulties with complex problem-solving. These cognitive complaints emerged in the context of a longstanding head tremor that began in 2007, which subsequently progressed to a right-hand resting tremor, rigidity, and gait instability by 2022, culminating in a formal diagnosis of Parkinson's disease three months prior to this evaluation. During the evaluation, Mr. Olivares was alert, fully oriented, and cooperative; despite requiring simplified instructions and occasional redirection, he put forth his best effort. Therefore, the current results are considered a valid and accurate reflection of his baseline neurocognitive functioning.

Regarding his cognitive strengths, Mr. Olivares demonstrated intact performance across several isolated domains, particularly when external structure was provided. His verbal abstract reasoning was a notable strength, falling within the high average range. Visual object naming was preserved and was within the average range. Visuoconstructional abilities were also notably preserved during copy conditions, as evidenced by his high average ability to copy a complex geometric figure and his successful correction of spatial errors when copying a visual model of a clock. Furthermore, while his unprompted memory retrieval was vulnerable, his ability to recognize and discriminate structured verbal material (stories) remained within the average range, suggesting a relative preservation of fundamental semantic storage when provided with recognition cues.

In contrast, Mr. Olivares exhibited prominent and severe cognitive deficits, most notably in executive functioning, processing speed, generative language, and free recall. Processing speed was globally compromised, with graphomotor speed and speeded word reading falling in the exceptionally low range. Executive dysfunction was profound; he demonstrated severe cognitive rigidity on a trial-and-error problem-solving task, committing an exceptionally high number of perseverative errors and failing to complete a single category. Executive planning and sequencing deficits were also evident on speeded visual sequencing tasks and during the free-draw condition of the clock drawing task, which was heavily reliant on abnormal structural scaffolding. Furthermore, both lexical and semantic fluency were exceptionally low. Memory testing revealed marked vulnerabilities in secondary encoding and retrieval; his immediate and delayed recall of both unstructured verbal lists and complex geometric designs fell in the exceptionally low range, complicated by rapid forgetting and the endorsement of false-positive errors. Bilateral fine motor dexterity was also below average.

Emotionally and behaviorally, Mr. Olivares is experiencing a significant degree of psychiatric distress. On self-report inventories, he endorsed mild symptoms of depression and moderate symptoms of anxiety. These objective findings align with the clinical interview, during which he and his wife described a worsening history of chronic anxiety, depression, and severe sleep disturbances characterized by insomnia and a history of physically acting out during nightmares. He reported profound psychological distress stemming from ongoing professional stressors, the tragic loss of his son, and political turmoil in his home country. Furthermore, his wife reported

the recent emergence of paranoid delusions, such as beliefs that they are being followed, alongside reports of him hearing ambiguous noises.

Functionally, Mr. Olivares's cognitive and physical declines have resulted in a loss of independence across several instrumental activities of daily living. While he continues to ambulate independently and manage basic self-care, he ceased driving following a fall in late 2025, a decision preceded by a history of getting disoriented while navigating familiar routes. He requires significant oversight for medication management; his wife must organize and dispense his complex regimen to ensure compliance and prevent missed doses. Additionally, his wife has assumed total responsibility for managing the household finances and navigating his medical appointments in the United States.

In clinical synthesis, Mr. Olivares presents with a severe neurocognitive disorder characterized by profound executive dysfunction, markedly slowed processing speed, impaired generative verbal fluency, and significant memory retrieval deficits, which stand in stark contrast to his preserved basic language skills, abstract reasoning, and high premorbid intellectual reserve. This specific pattern of impaired retrieval and executive regulation alongside intact semantic storage highlights a primary disruption in frontal-subcortical networks, effectively reducing the clinical likelihood of a primary cortical dementia such as Alzheimer's disease. Instead, his neurocognitive profile, coupled with the onset of resting tremors, physical rigidity, REM sleep behavior anomalies, and paranoid delusions, strongly points to underlying Lewy body pathology. While both Dementia with Lewy Bodies and Parkinson's Disease Dementia share this underlying pathology, they are distinguished clinically by the timeline of symptom onset. Because Mr. Olivares's established history demonstrates that his prominent Parkinsonian motor symptoms significantly preceded his cognitive decline and neuropsychiatric features, his presentation meets the diagnostic criteria for Mild Dementia, possibly due to Parkinson's Disease.

IMPRESSION Mild Dementia – Possibly due to Parkinson’s Disease with psychotic disturbance, mood disturbance, and anxiety

RECOMMENDATIONS

Medical & Psychiatric Management

1. **Neurological Follow-Up:** Mr. Olivares must continue close follow-up with his neurologist to monitor the progression of his Parkinson’s disease and cognitive decline. His medication regimen—specifically the timing and dosing of Carbidopa-Levodopa—should be reviewed, as he experiences significant fatigue that impacts his adherence.
2. **Psychiatric Medication Review:** Continued collaboration with his treating psychiatrist is strongly recommended. Given the emergence of psychotic features (e.g., paranoid delusions of being followed, auditory illusions) and REM sleep behavior anomalies (acting out dreams), careful psychopharmacological management is critical. His current use of Olanzapine should be routinely monitored, balancing its efficacy for his sleep and behavioral symptoms against the risk of exacerbating Parkinsonian motor symptoms.
3. **Physical Therapy and Fall Prevention:** Given his Parkinsonian gait, rigidity, and recent severe fall resulting in spinal fractures, ongoing physical therapy is recommended. Therapy should focus on core strengthening, balance, and safe transfers to prevent future injuries.

Safety & Supervision

1. **Driving Cessation:** Although Mr. Olivares recently stopped driving due to physical pain from his coccyx fracture, his severe executive dysfunction, significantly slowed processing speed, and prior history of getting disoriented on familiar routes indicate that he is no longer cognitively safe to operate a motor vehicle. Driving cessation must remain permanent.
2. **Medication Management:** Due to his profound executive planning deficits and the complexity of his pharmacological regimen, Mr. Olivares should not manage his own medications. His wife must continue to hold total responsibility for organizing, dispensing, and overseeing his daily medication intake via a pillbox system to prevent dangerous errors or omissions.
3. **Home Safety Modifications:** To mitigate further fall risks associated with his physical rigidity and gait instability, the family should implement environmental safety modifications in the home. This includes removing tripping hazards (e.g., throw rugs, clutter), ensuring adequate lighting at night, and installing grab bars in the bathroom.

Functional & Legal Planning

1. **Financial and Administrative Oversight:** Because Mr. Olivares demonstrates severe cognitive rigidity and a complete inability to adapt to problem-solving feedback, he is highly vulnerable to financial errors and exploitation. His wife should maintain full control over all household finances, international business affairs (e.g., the preschool in Venezuela), and the scheduling of medical appointments.
2. **Advance Directives and Legal Planning:** Given the progressive nature of Parkinson's Disease Dementia, it is strongly recommended that Mr. Olivares and his family consult with an elder law attorney. They should establish or update his Durable Power of Attorney, Medical Power of Attorney, and advance directives while he still retains the capacity to participate in these discussions and express his care preferences.

Cognitive & Behavioral Strategies

1. **Minimizing Anxiety Triggers:** Mr. Olivares's severe anxiety, obsessions, and sleep disturbances are heavily exacerbated by his continuous consumption of news broadcasts regarding the political situation in Venezuela. The family is encouraged to gently restrict and structure his access to this media, replacing it with calming, non-distressing activities, particularly in the hours leading up to bedtime.
2. **Bypassing Retrieval Deficits:** Mr. Olivares's memory difficulties are primarily driven by retrieval failure rather than a loss of information storage. Family members can support his communication by providing recognition cues (e.g., offering multiple-choice options or gentle hints) rather than asking open-ended questions that force him to retrieve information from scratch.
3. **Structured Daily Routine:** To compensate for his profound executive dysfunction and cognitive rigidity, Mr. Olivares will benefit from a highly structured and predictable daily routine. Minimizing unexpected changes and avoiding tasks that require multitasking or rapid shifting of attention will help reduce his frustration and fatigue.

Thank you for this kind referral.

Claudia V. Resendiz

Claudia V. Resendiz, Ph.D., ABPP
Board Certified, American Board of Clinical Neuropsychology

Electronically signed: 06/04/2026

Billing note: Technician, Solanch, performed face-to-face neuropsychological testing for 4 hours (96138 x1; 96139 x7). I interviewed the patient via telehealth services, reviewed medical records, integrated all information, and composed the report in its entirety for a total of 4 hours (96132 x1; 96133 x3).