



Reading an ADHD testing report can feel like opening a document written for three different audiences at once. Part of it is clinical, part educational, part psychological, and almost all of it is packed with numbers. Parents, adults being evaluated, teachers, and even referring physicians often land on the same question: what do these scores actually mean?

That question matters because ADHD testing reports are rarely just academic exercises. They influence treatment decisions, school supports, workplace accommodations, coaching plans, and, just as often, someone's sense of identity. I have seen people skim straight to the diagnostic impression and miss the richer story the scores are telling. I have also seen the opposite, where someone gets lost in the numbers and assumes a low score in one area means they are broadly incapable. Neither reaction is accurate.

A good [ADHD testing Denver](#) report does not simply label. It translates patterns. It shows where attention, impulsivity, working memory, speed, or executive functioning are getting in the way, and where strengths remain intact. The numbers only make sense when you know what kind of score you are looking at, what is being compared, and how the evaluator is using that information.

The first thing to understand, scores are comparisons

Most scores in ADHD testing are not raw tallies that stand on their own. They compare a person's performance to a reference group, usually people of the same age. If a 10-year-old completes a sustained attention task or an adult answers questions about memory and planning, the final score is interpreted against how others in that age band typically perform.

That sounds simple, but it changes how the report should be read. A score is not saying, "you got 18 right, therefore you have ADHD." It is saying, "your performance was lower, higher, or more variable than what we usually see in similar peers." Sometimes the comparison group is broad, sometimes it is carefully normed by age, and sometimes by gender in older instruments. The details depend on the test.

This is why the exact same raw performance can mean something different depending on age. A seven-year-old who misses certain details on a task may fall within the expected range. A college student doing the same thing on an age-adjusted version might stand out more clearly.

It is also why isolated low scores need context. Nearly everyone, including people with no disorder, gets a few weak scores across a long battery. Fatigue, stress, boredom, sleep debt, perfectionism, reading fluency, anxiety, and medication effects can all nudge a score. Skilled evaluators look for patterns, not single-number drama.

The score types you are most likely to see

ADHD testing reports tend to include a mix of score formats because different tests were designed by different publishers. That is one reason reports look so dense. A single evaluation may include standard scores on one measure, T-scores on another, percentiles on a third, and scaled scores in the cognitive section.

Here are the score types people most often encounter:

- **Standard scores**, often with an average of 100, compare performance to the norm group. A score near 100 is average, while scores meaningfully above or below that mark suggest relative strengths or weaknesses.
- **T-scores**, often with an average of 50, are common in behavior rating scales. Higher is not always better. On many ADHD symptom checklists, a higher T-score means more concerns were reported.
- **Scaled scores**, often averaging 10, are frequently used for subtests. They help show whether one skill area is weaker or stronger than another.
- **Percentile ranks** show the percentage of people in the norm group who scored at or below that level. A 25th percentile score does not mean 25 percent correct. It means the performance was at or above 25 percent of peers.
- **Qualitative ranges** such as average, low average, elevated, very elevated, or clinically significant translate the numbers into plain language categories.

That last point deserves emphasis. People often treat the descriptive labels as if they are the final word, but those labels sit on top of statistical cutoffs. “Low average” can sound alarming, even when it still falls within broad normal limits. “Average” can sound reassuring, even when a person’s daily life is clearly impaired. Both the number and the lived impact matter.

Why one “average” score does not rule out ADHD

This is one of the most common misconceptions in ADHD testing. Someone sees “average intellectual functioning,” “average memory,” or even “average attention score” and thinks the evaluation must be negative. That is not how ADHD works.

ADHD is not a global inability to think, remember, or focus. It is a regulation problem. Many people with ADHD can perform well in structured, novel, one-on-one testing settings, especially if the tasks are short, the room is quiet, and they are trying hard. Real life asks for something different: sustained effort across hours, transitions without prompts, organization without external scaffolding, emotional control under stress, and follow-through on uninteresting tasks.

A report can therefore show many average scores and still strongly support ADHD if the broader pattern fits. For example, an adult may have average reasoning and language skills, average learning on memory tasks, but clear weaknesses in working memory, time pressure, inconsistency, self-monitoring, and symptom ratings from both self and partner. A child may show age-appropriate basic skills in the office yet have repeated teacher ratings showing inattention, careless errors, incomplete work, and slow task initiation across the school week.

That gap between capacity and consistency is often the heart of the story.

Cognitive scores tell part of the picture

Many evaluations include cognitive testing, sometimes with familiar measures of reasoning, memory, processing speed, and related skills. People often assume these tests diagnose ADHD directly. Usually, they do not. They provide supporting evidence and help rule in or rule out alternative explanations.

Working memory scores often draw attention because they measure how much information a person can hold and manipulate in the moment. Weaknesses here can line up with ADHD symptoms such as losing track of multi-step directions, forgetting what to do next, or struggling to hold a thought long enough to act on it. But low

working memory is not unique to ADHD. Anxiety, language disorders, learning disabilities, sleep problems, and depression can affect it too.

Processing speed is another score that gets overinterpreted. A lower processing speed score may reflect slow visual scanning, cautious responding, graphomotor inefficiency, low motivation, perfectionism, or attentional drift. In children, it can show up as slow completion of worksheets or written output. In adults, it may show up as email backlog, trouble with forms, or tasks taking twice as long as expected. Still, slower speed alone does not equal ADHD.

What matters more than any single subtest is the overall pattern. Suppose someone has strong verbal reasoning, average visual reasoning, noticeably weaker processing speed, and lower working memory, plus real-world ratings showing disorganization and sustained attention problems across settings. That is more informative than one low score floating by itself.

Clinicians also consider variability. Large swings between subtest scores can be meaningful, especially when they echo everyday complaints. A person who can explain complex ideas fluently but misses simple details under time pressure may be showing a classic functional split.

Behavior rating scales often carry more weight than people expect

In many ADHD evaluations, questionnaires completed by the patient, parents, teachers, partners, or sometimes supervisors are central pieces of evidence. These scales measure observed behavior, not just test performance. That matters because ADHD is defined by symptoms and impairment in real life, across settings, over time.

Parents are sometimes surprised when teacher ratings weigh heavily. Adults are sometimes skeptical when a spouse's questionnaire becomes part of the clinical picture. Yet collateral reports are valuable because ADHD often includes poor self-monitoring. Some people underreport symptoms because they have normalized their struggles. Others overreport because they are exhausted, distressed, or comparing themselves to unrealistic standards. Multiple observers help the clinician triangulate.

Behavior rating scales often use T-scores. On many of these tools, higher T-scores indicate more concern. A T-score in the average range usually suggests the reported behavior is not standing out compared with age peers. A clearly elevated score suggests symptoms are being noticed at a level that is less typical. The exact cutoff varies by test, which is why the report's interpretive text matters.

Still, ratings are not perfect. Teachers differ in tolerance. Parents compare a child to siblings. Adults may answer based on their worst weeks. A highly structured classroom can suppress symptoms, while an unstructured environment can magnify them. This is one reason good reports discuss both the scores and the context in which they were obtained.

Percentiles are the most misunderstood number on the page

If I could fix one misunderstanding about ADHD testing reports, it would be this one. Percentiles do not show the percent correct. They show rank relative to peers.

If a person scores at the 16th percentile on a vigilance task, that does not mean they got 16 percent of the items right. It means they performed as well as or better than 16 percent of the comparison group, while 84 percent performed better. That is a very different statement, and often a much more concerning one.

Likewise, a score at the 75th percentile is not a school-style grade. It means the person performed better than most age peers on that measure. On some tasks, that might reflect genuine strength. On a symptom scale where

higher scores mean more problems, though, a higher percentile can reflect more severe concerns. This is why you always need to know what direction the scale runs.

When families misread percentiles, they often either panic unnecessarily or dismiss a meaningful finding. I once saw a parent relieved that a child had a “30” somewhere in the report because it sounded decent, not realizing it was the 30th percentile on a speeded attention measure and one of several scores clustering below expectation. The number alone gave false comfort.

What “clinically significant” usually means, and what it does not

Reports often use phrases such as clinically significant, elevated, at-risk, or very elevated. These labels can sound final and severe. In practice, they usually mean the score crossed a statistical threshold associated with meaningful concern on that measure.

That threshold does not automatically settle the diagnosis. It tells the clinician, “pay close attention here.” A clinically significant score on an ADHD symptom checklist supports the presence of prominent symptoms. It does not prove the symptoms began in childhood, appear in more than one setting, or are best explained by ADHD rather than anxiety, trauma, sleep deprivation, substance use, or another condition.

The reverse is also true. A score that falls just below a clinical cutoff does not prove everything is fine. Real people do not arrive in neat categories. Someone with a long history of compensating, high intelligence, intense parental support, or a structured job may hover below cutoff on one instrument while still showing convincing impairment elsewhere.

That is why the diagnostic section of the report should integrate history, ratings, performance data, developmental background, academic or occupational impact, and differential diagnosis. If it does not, the score labels are being asked to do more than they can.

The importance of effort, mood, sleep, and context

People tend to read reports as if every number reflects a stable trait. Often it does not. Testing captures performance on a particular day, under particular conditions.

A teenager tested during final exams, after five hours of sleep, may look more inattentive than usual. An adult with untreated anxiety may perform poorly on timed tasks because they rush, freeze, or second-guess themselves. Someone who is highly interested in puzzles may outperform their day-to-day functioning on certain cognitive tasks, because novelty carries them farther in the office than it does in paperwork, errands, or weekly planning.

Medication status matters too. Some clinicians test patients while they are taking prescribed stimulants, others ask them to come unmedicated for part of the process, depending on the referral question. Neither approach is universally right. The report should make clear what the person’s status was during testing. Scores obtained while a person is medicated may reflect capacity with treatment on board rather than baseline functioning.

This is also why a skilled evaluator will comment on behavior during testing. Did the person need instructions repeated? Start too quickly and make impulsive errors? Give up on boring tasks? Work slowly because they were overly cautious? Fidget, zone out, or lose place? Those observations often help the numbers make sense.

A diagnosis does not come from one test

This point bears repeating because marketing around ADHD testing can muddy the waters. No single computerized attention test, rating scale, or cognitive profile can diagnose ADHD in isolation. Some tools are useful for measuring attention, impulsivity, variability, and response control. They can support a diagnosis. They can also be normal in people who clearly have ADHD, or abnormal in people whose main problem is something else.

Proper ADHD testing is clinical synthesis. The evaluator gathers history, looks for symptom onset and duration, checks cross-setting impairment, reviews educational or occupational functioning, screens for learning disorders, anxiety, depression, trauma, sleep issues, autism traits when relevant, and sometimes substance use. The score sheet is one part of that larger process.

That is why two people can have similar numbers and different diagnostic outcomes. One may have lifelong ADHD with secondary anxiety. Another may have severe anxiety and burnout that mimic attention problems. The report should explain how the clinician reached the judgment, not simply recite data.

What to focus on when reading your own report

Most people do not need to master every psychometric detail. They do need to know how the findings translate into action. When I advise someone **pediatric ADHD testing Denver** to review a report, I tell them to look for five things:

- the evaluator's summary of the main pattern, not just isolated score descriptions
- whether symptoms showed up across settings and over time
- which weaknesses appear most functionally important, such as working memory, inhibition, organization, or sustained attention
- what alternative explanations were considered and how they were ruled in or out
- whether the recommendations actually match the documented profile

That last point is where many reports fall short. Recommendations should not read like generic handouts. If the report documents weak processing speed, recommendations might include reduced time pressure, chunked assignments, or fewer redundant tasks. If emotional impulsivity and planning are major concerns, therapy or coaching strategies should target those areas specifically.

When scores and lived experience do not seem to match

This happens more often than people expect. An adult may say, "My report looks mostly average, but my life is falling apart." A parent may wonder why a child's school struggles are intense when the testing did not look dramatic. Those mismatches deserve careful thought, not dismissal.

Sometimes the office setting reduced the demands that usually expose ADHD. Sometimes the measures were not sensitive to the exact problem, especially if the main issue is organization over long time frames rather than moment-to-moment attention. Sometimes another condition is adding noise. And sometimes the person is indeed functioning within normal cognitive limits but still has ADHD because impairment lies in regulation, consistency, and self-management rather than raw ability.

The opposite mismatch can happen too. A few scores may look weak, but the person is functioning well day to day. In those cases, clinicians ask whether the low scores reflect normal statistical scatter, temporary stress, language or cultural factors, sensory issues, or a testing day that simply did not capture usual functioning.

A thoughtful report acknowledges these possibilities. It does not force certainty where the evidence is mixed.

Questions worth asking after you get the report

The best testing reports answer most major questions, but even strong reports can leave room for discussion. If anything feels unclear, these are sensible follow-up questions to ask the evaluator:

- Which scores mattered most in forming the diagnosis, and why?
- Were any low scores considered less meaningful because of anxiety, fatigue, or other factors?
- How do the test findings connect to the problems we see at school, work, or home?
- What accommodations or treatments best fit this particular profile?
- If the diagnosis was not ADHD, what explanation fits the pattern better?

Those conversations often matter more than the raw numbers. A good evaluator can explain why a score that looked alarming may not be central, or why a score that seemed ordinary actually matters when paired with developmental history and real-world impairment.

The report is a map, not a verdict

The most useful way to think about an ADHD testing report is as a map of functioning. It marks terrain that is smooth, terrain that is uneven, and places where support would make travel easier. Some parts of the map are precise. Others are interpretive. But the goal is practical understanding.

If you are reading your own report, resist the urge to reduce yourself to the lowest number on the page. If you are reading a child's report, do not assume a single average score wipes away what teachers and parents have been managing for years. And if you are trying to decide what to do next, start with the pattern the report describes: where regulation breaks down, what conditions make it worse, what strengths can be leveraged, and what supports are likely to change daily life.

That is what the scores are for. Not to turn a person into data, but to make the data useful to the person.

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FAQ About ADHD testing Denver

How do you get tested for ADHD?

Start by discussing concerns with a qualified healthcare professional. An evaluation considers symptoms, developmental history, daily functioning, and information from people who know the child in different settings.

Is there a single test that diagnoses ADHD?

No single test establishes ADHD. Clinicians consider multiple sources of information and other possible explanations, including sleep problems, anxiety, depression, and learning difficulties.

Why do evaluators ask parents and teachers for information?

Reports from home, school, and other settings help the evaluator understand patterns and how difficulties affect everyday life. Different observations are useful context to discuss.

What should families ask before an evaluation?

Ask about the provider's qualifications, the evaluation's scope, required records, fees, appointment length, and how findings will be explained. Contact ElevateU to discuss the appropriate educational assessment for your child.