Cindy McCormack, LCSW
2290 East Avenue
Rochester, NY 14610

Adult Demographic Information

DATE:_____

NAME _____**DOB** _____**Age**_____

Street_____**Town**_____**ZIP**_____

Telephone: H(___)_____**W(___)**_____**Cell(____)**_____

Social Security #_____/_____/_____

Referral Source:_____

Marital Status:_____

Spouse/Partner (Name/Age)_____
(If applicable)

# of Children ____ **Ages of Children**_____

Race: ___Caucasian ___African American ___Hispanic ___Asian
___Native American ___Other:_____

Employer:_____

Emergency Contact:_____

Phone#: (day) _____**(eve)** _____

Primary Care Doctor:_____**Phone #:**_____

Current medical issues:_____

_____

Medications:_____

CURRENT PROBLEM OR REASON FOR COMING:_____

_____

Have you had any problems with any of the following:
(Please place a check mark on all that apply)

___Alcohol/Substance Abuse	___Marital Problems	___Sexual Function
___Sleep	___Work Functioning	___Eating Problems
___Memory/Thinking	___Family Problems	___Relationships

___Other (explain):_____

PREVIOUS TREATMENT: (Please list all out patient/in patient treatment)

Date	Type of Problem	Place Treated	Doctor/Therapist