

Birthmother Personal

Why do you want to place this child for adoption? _____

Are your parents/family aware of your adoption plans ___ Yes ___ No If yes, what is their Reaction? _____

Is there anyone that you know of that is against your adoption plan? ___ Yes ___ No. If yes, who and why? _____

Please describe the type of adoptive family you want for your child. Example: Age, religion, education, etc _____

What goals and hopes do you have for your life after placement? _____

Birthmother Physical Description

Height _____ Weight _____ Eye color _____ Hair Color _____ Skin Color _____ Body Type ___ Slender ___ Muscular ___ Large Boned ___ Petite

Describe your personality List your hobbies and interests _____

Please describe the type of family in which you were raised _____

Birthmother Education

Highest grade completed _____ or GED _____ What did you like about school ? Interests? _____

What are your educational goals? _____

Birthmother Health Information

What month of your pregnancy did you first see a health care worker? _____

Name of doctor or Clinic _____

Address _____

Phone # _____ Fax # _____ Hospital you plan to use?

_____ Address _____

Do you have or were you exposed to any of the following during your pregnancy?

Medical/Health	Birth Mother		Comments
	Yes	No	
Fever _____			
Rashes _____			
X-Rays/Radiation _____			
Chemicals _____			
Toxic/ Hazardous Wastes _____			
Sexually Trans. Diseases _____			
HIV/AIDS _____			
Diabetes/ Gestation _____			
Measles/Red or Rubella _____			
Mumps/Chicken Pox _____			
High Blood Pressure _____			
Toxemia _____			
Seizures/ with or without Eclampsia _____			
Eclampsia _____			
Pre-Eclampsia _____			
Hepatitis-A, B, C _____			
Tuberculosis _____			
Physical and/or emotional abuse _____			
Genetic illness or Condition _____			
Other diseases or Injuries _____			

Did you take any of the following during your pregnancy? If yes, how much a week did you take?				
	Yes	No	What Month in Pregnancy	How Much per Week
Alcohol _____				
Caffeine _____				
Cigarettes _____				
Cocaine/Crack(which) _____				
Heroin/Methadone (which) _____				
Marijuana/Pot _____				
Amphetamines (Uppers) _____				
Barbiturates (Downers) _____				
Paint or Glue Sniffing _____				
Others _____				

For the Following Medications, please list names of medication, if known			
	Yes	No	Name of Medicines
Prescription Meds			_____
Over the Counter Meds			_____
Seizure Meds			_____
Other			_____

Are you willing to have HIV and/or drug testing? ___ Yes ___ No Do You have Medical insurance? ___ Yes ___ No If yes, name and policy # _____

Medicaid ___ Yes ___ No Medicaid # and State _____

Number of pregnancies ___ 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6 + Vaginal deliveries ___ Yes ___ No

Cesarean ___ Yes ___ No Have you ever had an abortion? ___ Yes ___ No If yes, how many _____

Have you ever placed a child for adoption? ___ Yes ___ No If yes, please describe the circumstances and the dates _____

Siblings of baby to be placed for adoption:

#	Name	Birth Date	Sex	Full/Half Sibling	Height	Weight	Eyes	Hair
1	_____	_____	_____	_____	_____	_____	_____	_____
2	_____	_____	_____	_____	_____	_____	_____	_____
3	_____	_____	_____	_____	_____	_____	_____	_____
4	_____	_____	_____	_____	_____	_____	_____	_____

Please describe any health, learning, emotional, neurological and/or psychological problems or disabilities of any of the siblings

Do siblings live with you? ___ Yes ___ No If not, describe circumstances _____

Will this child be a full sibling to any of your other children? ___ Yes ___ No If yes, which ones

By Number _____

Birth Father Information

Name _____

First Middle Last

Address _____

Street City State Zip

Phone #'s _____

Home Work Emergency

Social Security # _____ Driver's License _____

Birth Date/Age _____ Was he adopted? ___ Yes ___ No

Ethnic Background ___ Caucasian ___ Hispanic ___ African-American ___ Asian

___ Pacific Islander ___ Native American (What Tribe) _____

Skin Color _____ Body Type ___ Slender ___ Muscular ___ Large Boned ___ Small Boned

Height _____ Weight _____ Hair _____ Eyes _____

Is he employed? _____

Business Address

City State Zip Phone Number

Any drug or alcohol problems? _____

Kind Duration

Is he incarcerated? _____

What for Where

Does he know about the plans to place? ___ Yes ___ No Is he supportive? ___ Yes ___ No

Has the Birth Father used or is using the following	Amount	How Much per Week
Alcohol _____		
Caffeine _____		
Cigarettes _____		
Cocaine/Crack (which) _____		
Heroin/Methadone (which) _____		
Marijuana/Pot _____		
Amphetamines (Uppers) _____		
Barbiturates (Downers) _____		
Paint or Glue Sniffing _____		
Others _____		

Maternal and Paternal Family History of Birth Mother and Birth Father

Health History	Birth Mother & Relatives			Birth Father & Relatives		
	Yes	No	Who	Yes	No	Who
Heart Trouble / Attack _____						
High / Low Blood Pressure _____						
Stroke _____						
Arthritis / Bursitis / Rheumatism _____						
Lupus _____						
Scoliosis _____						
Seizures / Convulsions / Epilepsy _____						
Hearing Disorders _____						
Sickle Cell Trait _____						
Anemia _____						
Health History	Birth Mother & Relatives			Birth Father & Relatives		
	Yes	No	Whom	Yes	No	Whom
Cancer: Breast / Lung / Ovarian/ Leukemia/other _____						
Diabetes _____						
Thyroid _____						
PKU _____						
Hormone Disorders _____						
Birth Defects:Heart/Cleft Palate/ Downs Syndrome/Cerebral Palsy _____						
Still Birth / SIIDS _____						
Schizophrenia _____						
Health History	Birth Mother & Relatives			Birth Father & Relatives		
	Yes	No	Whom	Yes	No	Whom
Manic depressive _____						
Depression _____						
Nervous Breakdown _____						
Learning Disorders _____						
Migraines _____						
Alcoholism _____						
Drug Dependency _____						
Medication allergies _____						
Brain Tumors _____						
Asthma/Hay Fever/Allergies _____						
Tuberculosis/Emphysema _____						
Pneumonia _____						
Cystic Fibrosis _____						

Health History	Birth Mother & Relatives			Birth Father & Relatives		
	Yes	No	Whom	Yes	No	Whom
Diseases of Stomach/ Liver / Intestines						
Gall Bladder / Gallstones						
Ulcers						
Eczema						
Hearing Loss						

Any other medical, emotional or mental conditions, illnesses or diseases not mentioned above:

Members of the family who are gifted or talented i.e. artistic, musical, mathematical, etc.

Future Contact Desires

In the past, adoptions tended to be sealed and both the adopted child and the parents who relinquished the child were uninformed about each other. In recent years, open adoptions have become a popular alternative and have been deemed healthier for the emotional well-being of all those involved. There are now adoption registers with each state where you have the option of listing your information and whether or not you might want to be contacted by the child when he reaches the age of eighteen. Please list your requests or desires about any future contact that you might want to have with the adoptive family. _____

After this child reaches adulthood:

If this child is curious and wants to meet you, are you willing to have a meeting arranged? ___ Yes ___ No. Would you prefer not to meet the child and to have the adoptive parents explain your reasons for giving him/her up for adoption? ___ Yes ___ No. Would you want to be contacted in case of a medical emergency if you could be of some help (whether the child was a minor or adult)? ___ Yes ___ No. Are you willing to write a letter to the child and perhaps enclose a photo of yourself and/or the birth father to be given to him/her at an appropriate time? ___ Yes ___ No.

Comments:

Although the information in the questionnaire will be kept confidential, your signature below will authorize us to release this information to prospective adoptive parents, if you choose to work with us.

Print Name

Date

Signature

Date