

# Biological Mother's Social History

(please print using blue or black ink)

Today's Date:	Due Date: _____ or Weeks Along: _____
Full Name (First, Middle, Last & Maiden)	Maiden: _____
Permanent Address (No PO Boxes)	
City	
State	
County	
Zip	
Home Phone (w/area code)	Can we leave identifying messages? Yes    No
Work Phone (w/area code)	Can we contact you at work? Yes    No
Social Security Number	
Driver's License or ID (State and Number)	
Place of Birth (City, State, County)	
Birth Date	
Your Race/Heritage	Caucasian      African-American      Hispanic Native American      Asian      Other _____ (check all that apply)
Nationality	
Occupation	
Marital Status	Single    Married    Separated    Divorced    Other If married, name of husband _____

Any Previous Marriages	
If Divorced (Date, County & State Finalized)	
U.S. Citizen	Yes No If no, passport/visa # _____
Height	
Weight (before pregnancy)	
Eye Color	
Skin Color	Fair Olive Tan Dark Other _____
Hair Color/Texture	Blonde Brunette Red Other: _____
	Straight Naturally Curly Wavy Texture: _____
Body Structure	
Blood Type	
Right/Left Handed	

CURRENT WORK SCHEDULE

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
In							
Out							

Name of employer \_\_\_\_\_

Address of employer \_\_\_\_\_

What state are you a resident of? \_\_\_\_\_ Month/year residency started? \_\_\_\_\_

How long (months/years) have you lived at your current address? \_\_\_\_\_

Date and time of first contact with us \_\_\_\_\_

Whom did you first speak with? \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

PREGNANCY AND ADOPTION DECISION

When and how did you first find out that you were pregnant? \_\_\_\_\_

Where and when do you think you conceived? \_\_\_\_\_

Does anyone in your family know about your pregnancy? Yes No

If yes, do they also know about your adoption plan? Yes No

If yes, are they supportive of your adoption plans? \_\_\_\_\_

Whom do you currently live with and are they supportive of your adoption plans? \_\_\_\_\_

Describe your feelings and the reasons why you are placing the child for adoption:

\_\_\_\_\_  
\_\_\_\_\_

Explain the type of home and family you want for your child: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Have you ever worked with another adoption agency or lawyer? If so, please list the name of the person or entity you worked with and the dates you worked with them:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

You are entitled to have an impartial witness (a person who does not have an employment, professional or personal relationship with the adoption entity or the prospective adoptive

parents) present when you sign your Consent to Adoption. Please indicate your preference by placing your initials next to your choice below:

\_\_\_\_\_ I would like \_\_\_\_\_ to act as my impartial witness at the time that I sign my Consent to Adoption. He/she can be reached at phone # \_\_\_\_\_ or \_\_\_\_\_

\_\_\_\_\_ I choose not to have such a witness.

### Relationship Between Biological Parents

Do you know the identity of the biological father? Yes No

If so, please provide his full name:

\_\_\_\_\_

Please provide his birth date: \_\_\_\_\_

Please provide his social security number: \_\_\_\_\_

Please provide his driver's license number and state of issuance: \_\_\_\_\_

Do you know where the biological father is now? Yes No

If so, please provide his address and phone number:

\_\_\_\_\_

If not, please provide the following:

Last known address: \_\_\_\_\_

Last known phone number: \_\_\_\_\_

Last known place of employment (including address and phone number): \_\_\_\_\_

\_\_\_\_\_

Names, addresses and phone numbers of relatives (including but not limited to parents, brothers, sisters, aunts, uncles, cousins, nieces, nephews, grandparents, great-grandparents, former or current in-laws, stepparents, or stepchildren who might know the biological father's identity and/or whereabouts): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Names, addresses and phone numbers of friends: \_\_\_\_\_

Detailed physical description (if uncertain of biological father's identity, include description of all possible biological fathers):

	Age	Race	Height	Weight	Eye Color	Skin Color	Hair Color	Hair Texture	Build
BF#1	_____	_____	_____	_____	_____	_____	_____	_____	_____
BF#2	_____	_____	_____	_____	_____	_____	_____	_____	_____
BF#3	_____	_____	_____	_____	_____	_____	_____	_____	_____

Is the biological father in any branch of the Armed Services of the United States? Yes  
No

If yes, list the branch and his last known location: \_\_\_\_\_

Is he also the father of any prior child(ren)? Yes No

Does he know about the pregnancy? Yes No

If yes, when was he informed of the pregnancy? \_\_\_\_\_

Does he know of your adoption plan? Yes No

Does he agree with your adoption plans? Yes No

Will he sign papers to place the child for adoption? Yes No

If yes, who first thought of the idea of adoption? \_\_\_\_\_

If no or unknown, please explain? \_\_\_\_\_

If applicable, describe your current relationship with the biological father. If you are no longer together, please state when the relationship terminated and why.

Are you involved in any litigation with the biological father? Yes No

If yes, please list the type of action, where it was filed and the names of any lawyers

involved: \_\_\_\_\_

\_\_\_\_\_

Is there any litigation pending regarding this child (custody, paternity, etc.)? Yes No

If yes, please list the type of action, where it was filed and the names of any lawyers

involved: \_\_\_\_\_

\_\_\_\_\_

Has the birth father lived with you before or during this pregnancy? Yes No

If yes, when? \_\_\_\_\_

Has he given or offered any support financially or emotionally during this pregnancy?  
(Explain in detail.)

\_\_\_\_\_

\_\_\_\_\_

Was he ever emotionally abusive of you during the pregnancy? (Explain in detail.)

\_\_\_\_\_

\_\_\_\_\_

Has he ever filed a petition to be declared the father of the child in any Court or otherwise  
been identified to be the father of the child? Yes No

If yes, what Court and when? \_\_\_\_\_

Please give the name, address and telephone number of any man with whom you were  
cohabiting at any time when conception of the child may have occurred.

\_\_\_\_\_

\_\_\_\_\_

Is there any possibility that any such man may be the biological father of the child? Why or  
why not?

\_\_\_\_\_

\_\_\_\_\_

Please provide the DATE and PLACE (including the TOWN or CITY, the COUNTY, and the STATE) where conception occurred.

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If uncertain, please list all places (including the TOWN or CITY, the COUNTY, and the STATE) you have lived in, traveled through, or visited where conception may have occurred, along with the DATE(S) on which conception may have occurred. \*\*If unsure of the date, calculate the likely date of conception based upon the birth or due date of child and give information for *the period beginning one month before and ending two months after the calculated conception date.*

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Please list all places (including the TOWN or CITY, the COUNTY, and the STATE) where you have resided since conception occurred.

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If you were married at any time you were pregnant and your husband is not the biological father of this baby, the courts require him to terminate his parental rights to the child. Please provide your husband's full name, permanent address, phone number w/area code, Social Security Number, and date of birth.

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Detailed physical description of your husband:

Date of Birth	Age	Race	Height	Weight	Eye Color	Skin Color	Hair Color	Hair Texture	Build
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____

If applicable, is your husband aware of the pregnancy? Yes No

If yes, is he aware of your adoption plans? Yes No

If applicable, will your husband consent to the adoption? Yes No

CHILDREN (other than child to be adopted)

Do you have other children? Yes    No

Do the children currently live with you? If no, explain \_\_\_\_\_

As to each, please give the following information (additional space next page):

Name and Date of Birth	Gender M/F	School Grade	Height __ft __ in	Weight ___ lbs	Hair Color	Eye Color	Complexion	Please circle
								Full Term, Overdue, Premature
								Full Term, Overdue, Premature
								Full Term, Overdue, Premature

\*\* Use the back of this form if necessary\*\*

PREGNANCY HISTORY

Is this your first pregnancy? Yes    No

If no, how many prior pregnancies? \_\_\_\_\_

Please indicate what occurred with these pregnancies: (indicate #)

Abortion: \_\_\_\_\_ Miscarriage: \_\_\_\_\_ Birth: \_\_\_\_\_ Vaginal delivery: \_\_\_\_\_ C-Section: \_\_\_\_\_

Were there any problems with prior pregnancies or births? Yes    No

If yes, please describe: \_\_\_\_\_

PREGNANCY INFORMATION

When is your due date? \_\_\_\_\_

What is the race of your baby? (check all that apply)

- Caucasian                       African-American                       Hispanic  
 Native American                       Asian                       Other \_\_\_\_\_

Have you taken any medication during this pregnancy? Yes No

If yes, what medication and at what time? \_\_\_\_\_

Have you been involved in any accidents during this pregnancy? Yes No

If yes, please describe in detail: \_\_\_\_\_

Have you had any complications during this pregnancy? Yes No

If yes, please explain: \_\_\_\_\_

Have you had X-ray, EKG, or radiation exposure during this pregnancy? Yes No

If yes, please explain: \_\_\_\_\_

#### LABOR AND DELIVERY INFORMATION

Are you seeing a doctor during your pregnancy? Yes No

If yes, Doctor's Name/name of practice: \_\_\_\_\_

Address: \_\_\_\_\_

Phone w/ area code: \_\_\_\_\_

If applicable, what month of your pregnancy did you begin prenatal care? \_\_\_\_\_

Please list all medical providers who have provided medical treatment or care to you and the child (include name, address, and telephone number).

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

At which hospital will you be delivering?

Name \_\_\_\_\_

Address: \_\_\_\_\_

Phone w/ area code: \_\_\_\_\_

Have you registered with the hospital yet? Yes No

Are you aware of their policies regarding adoption? Yes No

Have you spoken with anyone at the hospital about your adoption plan? Yes No

If yes, please list their name and their position or title \_\_\_\_\_

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#### MEDICAID INFORMATION

Do you have Medicaid? Yes No

If no, are you willing to apply? Yes No

If yes, date applied and Medicaid number? \_\_\_\_\_

What state/county is your Medicaid issued through? \_\_\_\_\_

Date benefits begin: \_\_\_\_\_

#### INSURANCE INFORMATION

Do you have medical insurance coverage? Yes No

If yes, Company name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Policy Number: \_\_\_\_\_

What percentage of your insurance will cover this pregnancy? \_\_\_\_\_

#### CONTACT WITH THE ADOPTIVE FAMILY

Do you want to select the adoptive family? Undecided Yes No

Do you want pictures/letters from the family after the adoption? Undecided Yes No

If yes, for how long? \_\_\_\_\_

Do you want to meet the adoptive family at the time of placement? Yes No

Do you authorize us to disclose your name, address and phone number to the adoptive parents? Please initial: yes \_\_\_\_ no \_\_\_\_

Use the following lines to include any additional information that you would like the adoptive family and your child to know about you or any characteristics or preferences you would like to see in an adoptive family.

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NATIVE AMERICAN-INDIAN TRIBAL MEMBERSHIP

It is important for us to know if you are a member of, or qualify to be a member of, any Native American Indian tribe, in compliance with federal law. **Please answer the following questions fully, completely, and to the best of your knowledge:**

Are you a member of any Native American Indian tribe? Yes No

Do you qualify to be a member of any Native American Indian tribe? Yes No

If yes, please indicate the tribe, location and your registration or identification number:

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Are any of your relatives members of any Native American Indian tribes? Yes No

Do any of your relatives qualify to be members of any Native American Indian tribes? Yes

No

If yes, please list the relative's name and the name and location of the tribe:

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### Biological Mother's Extended Family

(complete to the best of your knowledge)

	Your Mother	Your Father	Your Sister(s)	Your Brother(s)
Name				
Age or Year of Birth				
Race				
Education				
Hobbies/ Interest				
Occupation				
Height				
Weight				
Hair Color				
Eye Color				
Complexion (skin tone)				

\*\*\*Please list any additional information on the back of this form\*\*\*

### Biological Mother's Grandparents

(complete to the best of your knowledge)

	Your Mother's Mother	Your Mother's Father	Your Father's Mother	Your Father's Father
Name				
Age or Year of Birth				
Race				
Education				
Hobbies/ Interest				
Occupation				
Height				
Weight				
Hair Color				
Eye Color				
Complexion (skin tone)				

\*\*\*Please list any additional information on the back of this form\*\*\*



Have any relatives ever had custody of the child?

Yes    No

If yes, who and for how long? \_\_\_\_\_

Please list every address where the child has lived from birth to present, the names of all persons who resided at each address and the time period of residence:

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Has there ever been a court proceeding involving the child. If so, please list the type of proceeding (shelter, dependency, termination, paternity, custody, child support, etc.), who the parties were, where the suit was filed, whether it is still pending, its disposition or any other relevant matter.

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Please list all doctors who have treated the child, including all therapist and psychologist. Please provide their phone numbers and addresses.

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Please list all schools the child has attended, including the city and state:

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# Biological Mother's

## Medical History

Please complete the following information as accurately as possible. We have wonderful adoptive families willing to accepted children having any medical condition or exposed to any drugs or alcohol. The information is utilized to determine the health of your baby.

## HEALTH HISTORY OF BIOLOGICAL MOTHER

Place an "X" if the listed medical condition exists in your medical history or if any relatives or other family members have/had any of the conditions. If one of your relative's deaths was the result of a particular medical condition, note it on the comments section to the right of the condition and write the age at which they died.

Medical Condition	You	Your mother	Your father	Your brother(s) or sister(s)	Your children	Indicate cause, treatment, medications, parts of body involved, age onset or other explanations. When more than one condition or family member is involved please
HIV/AIDS (medications prescribed)						
Cancer (be specific)						
Diabetes (insulin dependent Yes No )						
Retardation: mental or physical (be specific)						
Down's Syndrome						
Hydrocephalus (water on the brain)						
Other developmental disorders (be specific)						
Diagnosed schizophrenia (medications prescribed)						
Diagnosed manic depressive (medications prescribed)						
Sickle cell anemia or trait						
Cystic fibrosis						
Leukemia						
Club foot or any orthopedic problem						
Harelip (Cleft lip) or Cleft palate						
Cerebral Palsy						
Muscular dystrophy						
Dwarfism						
Spina Bifida						
Congenital heart defect (be specific)						
Tuberculosis						

<b>Medical Condition</b>	<b>You</b>	<b>Your mother</b>	<b>Your father</b>	<b>Your brother(s) or sister(s)</b>	<b>Your children</b>	<b>Indicate cause, treatment, specific medications, parts of body involved, age onset or other explanations. When more than one condition or family member is involved please</b>
Hay fever						
Food allergy(s)						
Drug allergy(s) (name of drug(s))						
Other allergy(s) (be specific)						
Farsighted						
Nearsighted						
Different color eyes						
Night blindness						
Glaucoma						
Blindness (cause of blindness)						
Other visual problems (be specific)						
Sinus or nasal problems						
Ear infections						
Deafness (cause of deafness)						
Other ear problems (be specific)						
Teeth problems						
Gum disease						
Hypertension (high blood pressure)						
Heart murmurs						
Heart attack (coronary)						
Hemophilia (free bleeder)						
Stroke						
Anemia						
Heart Surgery (date of surgery)						

<b>Medical Condition</b>	<b>You</b>	<b>Your mother</b>	<b>Your father</b>	<b>Your brother(s) or sister(s)</b>	<b>Your children</b>	<b>Indicate cause, treatment, specific medications, parts of body involved, age onset or other explanations. When more than one condition or family member is involved please</b>
Any other heart or circulatory problems (be specific)						
Asthma (medications prescribed)						
Chronic Bronchitis						
Sudden Infant Death Syndrome (SIDS)						
Frequent pneumonia						
Other respiratory disorders						
Ulcers (be specific)						
Colitis						
Gall bladder problem						
High Cholesterol						
Obesity						
Anorexia/Bulimia						
Colon Cancer						
Other Digestive Disorders (be specific)						
Bladder Problems						
Kidney problems						
Speech problems						
Learning disability (specific diagnosis)						
Eczema or other skin conditions						
Alcoholism or heavy drinking						
Drug abuse (list specific drugs)						
Other mental or behavioral disorders (be specific)						
Multiple sclerosis						

Medical Condition	You	Your mother	Your father	Your brother(s) or sister(s)	Your children	Indicate cause, treatment, specific medications, parts of body involved, age onset or other explanations. When more than one condition or family member is involved please
Lou Gehrig's disease						
Seizures or convulsions (medications prescribed)						
Huntington's disease						
Epilepsy						
Migraine headaches						
Other nervous system disorders (be specific)						
Arthritis						
Hodgkin's disease						
Cysts, lumps, or growths						
Tumors						
Endometriosis						
Menstrual problems						
Problem pregnancies						
Other Medical Conditions (be specific)						
Other						
Other						
Other						

### CONFIDENTIAL DRUG/ALCOHOL USAGE

Please be very specific as to any drugs or alcohol used during your pregnancy, including the number of times and the dates of usage. This information is very important for the prediction of your child's health. This information will be passed along to the adoptive family and to the child's pediatrician. Place an 'X' in the applicable boxes and leave blank all other boxes.

<b>DRUG &amp; ALCOHOL USAGE</b>	<b>Used occasionally (1-5 times) during pregnancy</b>	<b>Used daily during pregnancy</b>	<b>Used weekly during pregnancy</b>	<b>Used monthly during pregnancy</b>
Cigarettes				
Alcohol				
Marijuana				
Cocaine				
Methamphetamines				
Heroin				
Ecstasy				
Methadone				
LSD				
Stimulants (Caffeine included)				
Depressants				
Diet Pills				
Tranquilizers				
Anti-Convulsants				
Other (be specific)				
Other (be specific)				

Please be specific about any prescription drugs used or prescribed during your pregnancy:

Name: \_\_\_\_\_

Prescribed for: \_\_\_\_\_

Length used: \_\_\_\_\_

Please list any other medical issues that were not covered in the information above:

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Please list any additional comments, concerns or questions you may have:

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I represent that the information contained in the Biological Mother's Social and Medical History is true and accurate. I acknowledge that the adoptive family and other parties will rely on this information in making a determination to proceed with the anticipated adoption and the Court will rely on this information during the adoption related proceedings. I hereby waive any claim of privilege and agree that the information contained on this form and any information provided by myself, my counselors and my physicians may be given to the adoptive parents, their agency, their attorney, and other state officials, including law enforcement authorities, through all communication medium.

I further understand that I am entering into a program that places children for adoption and any false statements may be viewed as perjury and in violation of penal laws of my state and may subject me to criminal and/or civil penalties under the law. I also understand that working simultaneously with more than one attorney, agency or adoptive couple may subject me to criminal and/or civil penalties under the law.

In my written and verbal communications in connection with my adoption plan, I have not provided any false or misleading information of any kind including information concerning myself, the biological father or the background or medical history of my family.

I hereby authorize the Adoption Entity to make inquiry about the truthfulness of the statements made in this document and the circumstances of this placement with other medical, legal and adoption professionals through all communication medium.

Please sign and date on the line below.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date