

Do you have Health Insurance or *Medicaid? _____

*If you do not have Medicaid would you like help in receiving it? _____

Weight gain during pregnancy (amount) _____

Have you had any Complications during this pregnancy (check one) YES _____ NO _____

If "Yes", please explain:

Have you had any X-Ray's, electrocardiogram, or radiation exposure during pregnancy? Yes _____ No _____

If "Yes", explain: _____

When did conception take place? _____

Approximate Date

Month

Where did conception take place? _____

City

County

State

BIRTH FATHER INFORMATION

Do you know who the father is? _____

His name _____

His phone number _____ Is he aware of this pregnancy? Yes _____ No _____

Does he know of your plans to place the child for adoption? Yes _____ No _____

His current address _____

Street

City

State

Zip

Is the father willing to give up his parental rights? _____

Are the two of you married? _____

Have you been previously married? _____

If you are married or divorced we will need a copy of your marriage license or divorce decree.

Describe your current relationship with him _____

Fathers race _____ Height _____ Weight _____

Is he or has he ever been abusive to you? _____

Are you aware of any individual whose visitation rights have been restricted through the courts, (court ordered protective orders, court ordered restrictions, etc). Please list all that apply: _____

CONDITIONS DURING PREGNANCY

(circle one & date)

German measles: Yes No Date _____

Venereal Disease: Yes No Date _____

Virus: Yes No Date _____

Infections: Yes No Date _____

Accidents: Yes No Date _____

Any known sexually transmitted disease and treatment? _____

DELIVERY HISTORY INVOLVING THIS CHILD

Full Name of Child _____ Birth date _____ Time of Birth _____

Place of Birth _____
City County State

Childs Gender: Male _____ Female _____

Duration of labor: _____ Blood type _____

Type of delivery: Natural _____ Caesarian _____ R.H. Factor _____

Forceps: YES _____ NO _____ (Check one) RBC _____ DATE _____

Serology _____ Anesthesia/medication used _____

BACKGROUND INFORMATION FOR PREGNANCY WITH THIS CHILD (To be completed by birth mother)

Was the baby's father aware of the pregnancy? Yes _____ No _____ Not Sure _____

Did you try notifying him of your pregnancy? _____

Was the baby's father a genetic relative of yours? Yes _____ No _____

If yes, how is he related? _____

Month prenatal care began for this pregnancy? _____

Were there any complications? Yes _____ No _____ If yes, explain _____

Was there any sexual or physical abuse during pregnancy? Yes _____ No _____

Was there any venereal disease and treatment during pregnancy? Yes _____ No _____

Did you have food cravings during pregnancy? Yes _____ No _____

MARITAL HISTORY

Are you currently married Yes _____ No _____ If yes, give the date of marriage _____

Have you been married previously? Yes _____ No _____ If yes list dates of marriage(s) and divorce (s) from or death(s) of spouses _____

Is the child being placed the child of current spouse? Yes _____ No _____ If not describe your relationship with the other parent _____

CHILDREN OTHER THAN THE CHILD TO BE ADOPTED

If you have other children, list them below, include any children previously placed for adoption. If any child is deceased, Please provide cause of death.

AGE	SEX	SCHOOL GRADE	HEIGHT	WEIGHT	HAIR	EYES	COMPLEXION	SPECIAL CHARACTERISTICS

If any children listed above had unusual physical or mental illness, give details: _____

YOUR PHYSICAL CHARACTERISTICS

Eyes: _____ Hair: _____ Complexion: _____ Height: _____

Weight: _____ Body Build: _____ Ethnicity: _____

Nationality/Descent: _____ Blood Type: _____ RH Factor: _____

Do you wear glasses? Yes _____ No _____ Languages Spoken: _____

EMPLOYMENT INFORMATION

Are you employed? Yes _____ No _____ Current Employment (type of job): _____

What is your current work Schedule? _____

Previous Employment (type of job): _____

Career Goals: _____

EDUCATION

Number of years attended: *Grade School* _____ *High School* _____ *College* _____ *Major* _____ *GED* _____

Vocational or other Training: _____

Educational Goals: _____

RELIGION

Do you have preference regarding the religious practice of the adoptive family for your child:? Yes _____ No _____

If yes, please specify _____

Would you object to your child being placed with a family whose religion is different from your own?

Yes: _____ No: _____

CRIMINAL HISTORY

Have you ever been charged with a crime? (Misdemeanor or Felony) Yes _____ No _____

If Yes please list & explain all charges, time spent in jail or community service, length of probation and if you are still on probation who is your P.O. _____

Do you have an open CPS (Child Protective Service) Case? Yes _____ No _____

If Yes please explain the reasons for the case and please give us the name of the Social Worker Involved with your case. _____

REASONS FOR PLACEMENT

What are the reasons you don't feel you are able to parent this child?

If situations change, will you change your mind? _____

Why or why not? _____

What kind of influence do friends and family have on your decision?

Tell us in detail, who is aware and supportive of your decision to place your child for adoption? _____

What are your plans for delivery? Are you going to deliver in your state or deliver in Utah? _____

If you stay in your state, Who is going to be in the delivery room with you?

Are they supportive of your decision? _____

Are you going to hold and care for your child in the hospital prior to signing the consent forms? _____

If you plan to deliver in Utah do you want the Adoptive Parents in the delivery room with you? _____

If you choose not to have the Adoptive Parents in the Room with you, will you want them at the hospital after delivery to help care for the baby? _____

If you stay in your home State, are you willing to let the baby be discharged to our Social Worker and placed in Cradle Care (NOT FOSTER CARE) for 2-4 days until your rights are terminated? _____

What thinking went into your decision to place this child for adoption?

If the child was not placed at birth, give brief information on health and development until the time placement was made:

What is your current feeling about being contacted by the child when he/she is an adult?

Utah has a Mutual Consent Registry; if you place your child for adoption here in the State of Utah or Place him/her with a Utah Family you will be able to submit your name to the registry. Your child will then be able to submit his/her name to the registry and when he/she is the age of 21 and both parties consent to this you may meet. It only can happen if BOTH PARTIES submit their information. Would you like more information regarding this program? Yes _____ NO _____

ADOPTIVE PARENT GOALS

All for Love Adoptions, Inc. will not discriminate against any persons because of their race, ethnicity, religion or marital status.

Please explain the race, religion and type of family you would like your child to be

Parented by _____

Describe the "perfect" adoptive family _____

Do you wish to look at profiles of adoptive parents and choose the family for your child? _____

If yes, we will send out profiles in the last six weeks of pregnancy. You may choose the family and talk to them if you wish.

Describe what kind of adoption you would like to have (open/closed) _____

On a scale of 1 to 5 five being the most, how committed are you to placing your child for adoption?

Not committed < 1 2 3 4 5 >VERY Committed

FAMILY HISTORY

Please give a brief description of your childhood home and family life. _____

RELATIONSHIP BETWEEN BIRTH PARENTS

Please give a brief description of how you met each other, the quality of your relationship, interests shared, and involvement during pregnancy and future relationship. _____

MEDICAL CONDITION	NO	Not Known	YES Self	YES-RELATIVE (Specify)	COMMENTS
<u>CONGENITAL IMPAIRMENTS</u>					
1. Club foot or any other orthopedic problem					
2. Cleft lip and/ or cleft palate					
3. Chromosome abnormality					
4. Down syndrome					
5. Hydrocephalus					
6. Muscular dystrophy					Parts of body involved? Age of onset?
7. Spina bifida					
8. Congenital heart defect					
9. Tay-Sachs disease					
B. <u>ALLERGIES</u>					
1. Eczema or other skin condition					Any cause known? What treatment? What medication?
2. Hay fever or other allergy					
3. Drug allergy					To What Drugs?

C. <u>EYE, EAR, DEVELOPMENTAL DISORDERS</u> 1. Blindness, glaucoma, color blindness or other visual problems					
MEDICAL INFORMATION	NO	Not Known	YES Self	YES-RELATIVE (Specify)	COMMENTS
2. Hearing impaired or other ear problems					Age at onset? Special education required
3. Speech problems					
4. Learning disability					Any diagnosis? Hospitalization?
5. Retardation: mental or physical					
D. <u>CIRCULATORY DISORDERS</u>					
1. Hemophilia					
2. Sickle cell anemia or trait					
3. Hypertension (high blood pressure)					Age of onset? What treatment? Hospitalization?
4. Stroke					
5. Heart attack (coronary)					
6. Arthritis					Age at onset? What treatment?
7. Kidney Disease					Age at onset? What treatment?
E. <u>HORMONAL DISORDERS</u>					
1. Diabetes					Age at onset? What treatment?
2. Thyroid disorder					
F. <u>RESPIRATORY DISORDERS</u>					
1. Asthma					Any cause known? What treatment?
2. Tuberculosis					Age at onset?
<u>MENTAL & BEHAVIORIAL DISORDERS</u>					
1. Schizophrenia					Age at onset? What treatment? Hospitalization?

2. Bi-Polar					
Alcoholism or heavy drinking					
Drug usage					Kind, amount, and when taken?

MEDICAL CONDITION	NO	Not Known	YES Self	YES-RELATIVE (Specify)	COMMENTS
H. LYMPHATIC DISORDERS					What kind? Age at onset? What part of the body?
1. Cancer					
2. Tumors					
3. Cystic fibrosis					
4. Hodgkin's disease					
I. NERVOUS SYSTEM DISORDERS					
1. Multiple sclerosis					
2. Huntington's Chorea					
3. Cerebral palsy					
4. Seizures or convulsions					
5. Epilepsy					
J. INFECTION, HOSPITALIZATION					Diagnosis
1. Repeated attacks of fever with known infection					
2. Repeated severe infection necessitating hospitalization					
3. Hospitalization, operation, or injury					What for? When?
K. OTHER IMPAIRMENT,					

ALLERGY, DISORDER OR DISEASE						
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MEDICATIONS AND OTHER SUBSTANCES USED DURING THIS PREGNANCY AND 5 YEARS PRIOR TO THIS PREGNANCY

Indicate in appropriate space medication/drugs taken during pregnancy involving this child. Also list any other substances used during 5 years prior to this pregnancy:

<u>MOTHER ONLY</u>	<u>YES</u> (circle one)	<u>NO</u>	<u>MONTH</u> (If during this pregnancy)	<u>YEAR</u> (If prior to this pregnancy)	<u>TYPE, FREQUENCY, AMOUNT</u>
Aspirin	YES	NO			
Antibiotics	YES	NO			
Antihistamines, IF YES, TYPE _____	YES	NO			
Hormones, IF YES, TYPE _____	YES	NO			
Cortisone	YES	NO			
Diet Pills, IF YES, TYPE _____	YES	NO			
Sleeping Pills, IF YES, TYPE _____	YES	NO			
Nerve Pills, Tranquilizers, IF YES, TYPE _____	YES	NO			
Medicine for Cancer IF YES, TYPE _____	YES	NO			
Heart/Blood Pressure Meds. IF YES, TYPE _____	YES	NO			
Thalidomide	YES	NO			
Medicine for Nausea IF YES, TYPE _____	YES	NO			
Medicine for Convulsions IF YES, TYPE _____	YES	NO			
Nose Drops	YES	NO			
Alcohol	YES	NO			
Amphetamines, IF YES, TYPE _____	YES	NO			
Barbiturates IF YES, TYPE _____	YES	NO			
Cocaine	YES	NO			
Heroin	YES	NO			
LSD	YES	NO			
Marijuana	YES	NO			

Caffeine (coffee, tea, etc)	YES	NO			
Cigarettes	YES	NO			
Any other prescription drugs.	YES	NO			
FATHER ONLY	CIRCLE ONE		TYPE	FREQUENCY	AMOUNT
Alcohol	YES	NO			
Amphetamines	YES	NO			
Barbiturates	YES	NO			
Cocaine	YES	NO			
Heroin	YES	NO			
LSD	YES	NO			
Marijuana	YES	NO			
Caffeine (coffee, tea, etc.)	YES	NO			
Use Tobacco	YES	NO			
Any other prescription drugs. If YES, TYPE	YES	NO			

Any known sexually transmitted disease and treatment? _____

BOTH BIRTH PARENTS PLEASE ANSWER

What is your hair color? _____ Is it naturally curly or straight? _____

Is it fine or thick? _____ Do you like to wear it long or short? _____

The color of your eyes? _____ Do you wear glasses or contacts? _____

If so, what age did you start wearing them? _____

And, are you near-sighted or far-sighted? _____

Was there ever a need to wear braces? _____ How long did you have them? _____

Is your skin fair or dark? _____

Is your skin sensitive? _____ Do you have any allergic reactions to any thing? _____

Have you ever had a complexion problem? _____ Is your skin dry, oily normal? _____

Your height? _____ Your average weight? _____ Are you big-boned or small-boned? _____

In case it's a girl, how early did you start your menstrual cycle? _____

Do you have any problems with it, such as cramping, headaches, etc.? _____

Please Explain: _____

What time of month does it occur, late, middle or early month? _____

What are your hobbies and interests? _____

What are your favorite foods and drinks? _____

Are you allergic to any foods or drinks? If so, what are they? _____

What is your favorite restaurant? _____

What is your favorite color? _____

What is your favorite season? _____

What is your favorite holiday? _____

What are/were your favorite courses in school? _____

Are/were you involved in any school activities? _____

If so, what are/were they? _____

EXTENDED FAMILY OF: BIRTH MOTHER: _____ BIRTH FATHER: _____

FIRST NAME	AGE	RACE	EDUCATION	OCCUPATION	PHYSICAL DESCRIPTION	
YOUR MOTHER					Height Hair Complexion	Weight Eyes
YOUR FATHER					Height Hair Complexion	Weight Eyes
YOUR SISTER(S)					Height Hair Complexion	Weight Eyes
YOUR BROTHER(S)					Height Hair Complexion	Weight Eyes

Do you have any special questions or concerns that we can help you with?

All for Love Adoptions, Inc. wants to make you aware that our employees, volunteers, agents, consultants or independent contractors may provide services to both the birth parents and the adoptive parents which may be a potential conflict of interest.

I, _____ hereby certify to the best of my Knowledge and honor that the information provided by me is true and correct. I Understand that misrepresenting information of this kind is unlawful.

Signature of the Birth Mother _____

Signature of the Birth Father _____

Date _____

Thank you for taking the time to fill this out, we know it was very time consuming. We feel this is important for us the agency to have and for the adoptive families to share with your child. If you have any questions please feel free to ask and we would be more than happy to help you.

We welcome you to our services, and look forward to establishing a long term friendship with you. We love you and we will do our very best to serve you in any way that we can. We ask a few things of you and that is to call and check in with us at least twice a month. An easy way to remember is to call us after your doctor appointments. We like to be updated on your progress and make sure you are getting the care you need. If weeks go by and we don't hear from you, then we assume you no longer wish to place your child for adoption. Instead of making us worry and wonder please just call and let us know that you have changed your mind, this is your child up until if or when you sign relinquishments. Thank you again for choosing to work with us. Our phones are *always open* to you 24 hours a day 7 days a week.

Toll free **1-877-525-2055 ext 1**

