BIRTHFATHER'S BACKGROUND INFORMATION

IDENTIFYING INFORMATION PAGE

If you do not want the information on this page shared with the adoptive parents, please initial the line below your signature at the bottom of this page.

Name: _____

Also Known As: _____

Address: _____ County: _____

City:_____ State/Province: _____ Zip/Postal Code:_____

Home Tel.#_____ Work Tel.#_____

Social Security Number:_____ Drivers License Number:_____

Place of Employment:_____

In Emergency Contact:_____ Tel.#:_____

Address: _____ County: _____

Street:_____ Country: _____

City:_____ State/Province: _____ Zip/Postal Code:_____

If Married, Name of Spouse:_____

Address: _____ County: _____

City:_____ State/Province: _____ Zip/Postal Code:_____

In Emergency Contact:_____ Tel.#:_____

Social Security Number:_____

Place of Employment:_____

Completed by: _____ Date:_____Signature:_____

If not completed by Birthfather, please print name and relationship to Birthfather:

_____

I do not want this identifying information page shared with the adoptive parents_____

NON-IDENTIFYING BACKGROUND INFORMATION OF BIRTHFATHER

First Name:_____ Age:_____

Date of Birth:_____ Place of Birth:_____

Religion:_____

Do you have a preference for the Adoptive Parents' religion? Yes _____ No _____

Preference: _____

Is there any religion which you find unacceptable?_____

Racial Background:_____

Nationality Background:_____

If Native American, Tribal Affiliation:_____

Where Enrolled?_____

Primary Language:_____ Secondary Language:_____

PHYSICAL DESCRIPTION

Height:_____ Weight:_____ Eye Color: _____

Complexion:_____ Hair Color & Texture: _____

Distinguishing Physical Features:_____

MEDICAL

Present General Health:_____

Blood Type:_____ Right/Left Handed:_____

Wear Glasses? Yes_____ No_____ Contact Lenses? Yes_____ No_____

If yes, for what condition?_____

Childhood Illnesses:_____

Age at Onset of Puberty:_____

MEDICAL (Continued)

Major Surgery? Yes_____ No_____ If Yes, for what condition and when? _____

_____

Medications, Drugs or Alcohol Used:_____

Do you smoke? Yes_____ No_____ If Yes, # of packs per day:_____

Congenital Defects of Father: Yes_____ No_____ If Yes, please describe: _____

_____

Have you placed any other children for adoption? Yes_____ No_____

If Yes, please describe placement (sex of child, when placed; which agency or attorney, etc.)

_____

_____

Have you been tested for AIDS? Yes_____ No_____

If Yes, when?_____

Have you been tested for Hepatitis? Yes_____ No_____

If Yes, when?_____

EDUCATION

Last Grade Completed:_____ Average Grade in School:_____

Favorite Subjects:_____

Difficult Subjects:_____

Extracurricular Activities:_____

Name of Last School Attended:_____

Additional Training Obtained:_____

Plans for Future Schooling:_____

PERSONAL

Does your family know of your adoption plans? Yes _____ No _____

If Yes, who knows and are they supportive?_____

If No, do you plan on letting them know in the future? Yes _____ No _____

If any members of your family who do not know about your adoption plans found out about them, would they be supportive of the adoption? Yes _____ No _____

Are you interested in future contact with child?_____

If Yes, please describe:_____

Have you had any psychological counseling?_____

Name of Counselor:_____

Address: _____ County: _____

City:_____ State/Province: _____ Zip/Postal Code:_____

Tel.#.:_____

If No, would you like some?_____

Was anyone in your family adopted?_____

Has anyone in your family placed a child for adoption?_____

Significant Childhood Events:_____

Describe your personality:_____

_____

Hobbies, Special Skills, Talents and Interests:_____

_____

Relationship with Parents:_____

Relationship with Siblings:_____

Plans for the Future:_____

MARITAL AND FAMILY HISTORY

Marital Status:_____ Place of Birth: _____

Date of Birth of Wife: _____ Place of Birth:_____

Date of Marriage: _____ Place of Marriage:_____

Date of Divorce: _____ Place of Divorce:_____

Number of Marriages: _____ Is spouse birthmother? _____

Are you living with anyone? _____

Do you have any children? _____ If yes, please continue:

First Child:

Sex: _____ Date of Birth: _____ Place:_____

Health and Physical Condition:_____

Height: _____ Weight: _____

Color of Hair: _____ Color of Eyes:_____

Complexion: _____

Developmental Problems: _____

Current Whereabouts: _____

Is birthmother the mother of this child? _____

Second Child:

Sex: _____ Date of Birth: _____ Place:_____

Health and Physical Condition:_____

Height: _____ Weight: _____

Color of Hair: _____ Color of Eyes:_____

Complexion: _____

Developmental Problems: _____

Current Whereabouts: _____

Is birthmother the mother of this child? _____

Third Child:

Sex: _____ Date of Birth: _____ Place:_____

Health and Physical Condition:_____

Height: _____ Weight: _____

Color of Hair: _____ Color of Eyes:_____

Complexion: _____

Developmental Problems: _____

Current Whereabouts: _____

Is birthmother the mother of this child? _____

Please use the back of this form if you have more than three children.

PLEASE SET FORTH A BRIEF STATEMENT EXPLAINING YOUR REASONS FOR PLACING THE CHILD FOR ADOPTION:

_____

_____

_____

RELATIONSHIP BETWEEN BIRTHPARENTS

Please give a brief description of your current relationship. If you are no longer together, please state when and why the relationship terminated:

_____

_____

Is the mother of the child a relative of yours? Yes_____ No_____

If Yes, how is she related?_____

Is the birthmother also the mother of any other child(ren) of yours? Yes_____ No_____

Do you agree with her plans with regard to placing the child for adoption? Yes_____ No_____

Will you sign surrender papers? Yes_____ No_____

Have you lived with the birthmother before or during this pregnancy? Yes_____ No_____

If Yes, when?_____

Have you 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? _____

Have you ever supported the birthmother during this pregnancy? Yes_____ No_____

Have you ever offered her support during the pregnancy? Yes_____ No_____

Has she lived with you before or during this pregnancy? Yes_____ No_____

If Yes, when? _____

Have you ever had custody of any children? Yes_____ No_____

If Yes, when?_____

Have you ever contributed to the support and maintenance of any child? Yes_____ No_____

If Yes, describe: _____

Have you ever visited the child or shown an interest in the welfare of the child? Yes_____ No_____

PHYSICAL DESCRIPTION OF YOUR PARENTS

Physical Characteristics of Mother of Birthfather:

Height: _____ Weight: _____ Race:_____

Eye Color: _____ Hair Color & Texture:_____

Date of Birth: _____ Place of Birth:_____

Is mother living? _____ If no, age and cause of death:_____

Physical Characteristics of Father of Birthfather:

Height: _____ Weight: _____ Race:_____

Eye Color: _____ Hair Color & Texture:_____

Date of Birth: _____ Place of Birth:_____

Is father living? _____ If no, age and cause of death:_____

MULTIPLE BIRTHS IN FAMILY

Has anyone in you family given birth to Twins, Triplets, etc.?_____

EMPLOYMENT HISTORY

Current Occupation:_____

Length of time employed at current job:_____

Previous Occupation:_____

Military Service: _____ Branch of Service:_____

INSURANCE COVERAGE

Do you have medical insurance or Medicaid?_____

If yes, type of insurance:_____

Plan Name and Identification or Medicaid Number:_____

_____

BIRTHFATHER/FAMILY MEDICAL HISTORY

Please check any of the following that have occurred in your family. Also state age of onset.

	Your Self	Your Child	Your Mother	Your Father	Your Sisters	Your Brothers	Your Father's Father	Your Father's Mother	Your Mother's Father	Your Mother's Mother
Age of Person										
Acne										
AIDS/HIV										
Alcohol abuse or addiction										
Allergies (specify type)										
Anemia										
Arthritis										
Asthma										
Autism										
Bipolar Disorder										
Cancer (type/ location)										
Cerebral Palsy										
Chicken Pox										
Club Foot										
Convulsions										
Cystic Fibrosis										

Please check any of the following that have occurred in your family. Also state age of onset.

	Your Self	Your Child	Your Mother	Your Father	Your Sisters	Your Brothers	Your Father's Father	Your Father's Mother	Your Mother's Father	Your Mother's Mother
Diabetes										
Down's Syndrome										
Drug Abuse or Addiction										
Emphysema										
Epilepsy										
Eye Problems (specify)										
German Measles										
Glasses / Contacts (condition?)										
Gonorrhea										
Heart Disease										
Hemophilia										
Hepatitis (A/B/C?)										
Herpes										
High Blood Pressure										

Please check any of the following that have occurred in your family. Also state age of onset.

	Your Self	Your Child	Your Mother	Your Father	Your Sisters	Your Brothers	Your Father's Father	Your Father's Mother	Your Mother's Father	Your Mother's Mother
Kidney Disease										
Learning Disabilities										
Lupus										
Major Depressive Disorder										
Measles										
Mumps										
Multiple Sclerosis										
Muscular Dystrophy										
Obesity										
Obsessive-Compulsive Disorder										
Panic Disorder										
Paranoia / Psychological Disorder										
Pervasive Developmental Disorder										
Psychological Problems										
Rheumatic Fever										

Please check any of the following that have occurred in your family. Also state age of onset.

	Your Self	Your Child	Your Mother	Your Father	Your Sisters	Your Brothers	Your Father's Father	Your Father's Mother	Your Mother's Father	Your Mother's Mother
Scarlet Fever										
Schizophrenia										
Schizoaffective Disorder										
Sickle Cell Anemia										
Sight, hearing or speech impairment (specify)										
Spinal Bifida										
Stroke										
Syphilis										
Tay Sachs Disease										
Toxemia										
Toxoplasmosis										
Thyroid Disease										
Tuberculosis										
Tourette's Syndrome										
Any other disease (specify)										
If any of the above are deceased, specify age and cause of death										