

# INFORMATION ABOUT THE BIRTH MOTHER

CHILD'S NAME:		CASE NUMBER:
CASE WORKER'S NAME:	AGENCY'S NAME:	

## INSTRUCTIONS FOR COMPLETION:

- Print clearly - using ink.
- Complete all items. If you don't know the answer to an item, indicate "unknown".
- The AD 67 form is divided into two separate parts. Section I consists of "identifying" information and will be kept confidential. None of this information will be given to your adopted child or his/her adoptive parents unless you have given us written permission to do so. Section II consists of "nonidentifying" information. California Adoption Law requires that a copy of Section II which is medical, psychological and social information be given to the adoptive parents before the finalization of the adoption and upon written request of the adoptee when he/she reaches age 18.

## SECTION I — IDENTIFYING INFORMATION ABOUT BIRTH MOTHER

### A. NAME/ADDRESS:

BIRTH MOTHER'S NAME (FIRST, MIDDLE, LAST)		MAIDEN NAME	OTHER NAMES KNOWN BY	
SOCIAL SECURITY NUMBER	DRIVER'S LICENSE NUMBER	DATE OF BIRTH (MO, DAY, YR)	BIRTHPLACE (CITY, STATE, COUNTRY)	
CURRENT ADDRESS (STREET, CITY, STATE, ZIP CODE)				TELEPHONE NUMBER ( )
PERMANENT MAILING ADDRESS (STREET, CITY, STATE, ZIP CODE) *				PERMANENT TELEPHONE NUMBER ( )
RESTRICTIONS FOR USE OF PERMANENT MAILING ADDRESS, IF ANY				

### B. BIRTH MOTHER'S PARENTS - (The parents who raised you)

NAME OF BIRTH MOTHER'S MOTHER (FIRST, MIDDLE, LAST)			NAME OF BIRTHMOTHER'S FATHER (FIRST, MIDDLE, LAST)		
ADDRESS	STREET	CITY	ADDRESS	STREET	CITY
STATE	ZIP CODE		STATE	ZIP CODE	
DOES YOUR MOTHER KNOW OF THIS ADOPTION? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN			DOES YOUR FATHER KNOW OF THIS ADOPTION? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN		
IF IN THE FUTURE WE NEED TO LOCATE YOU, MAY WE CONTACT YOUR MOTHER FOR ASSISTANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO			IF IN THE FUTURE WE NEED TO LOCATE YOU, MAY WE CONTACT YOUR FATHER FOR ASSISTANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO		

### C. PATERNITY OF MINOR:

NAME OF CHILD'S BIRTH FATHER (FIRST, MIDDLE, LAST)	PERMANENT TELEPHONE NUMBER (AREA CODE) NUMBER
LAST KNOWN ADDRESS (STREET, CITY, STATE, COUNTRY IF OUTSIDE U.S.A.)	

### D. MARITAL HISTORY:

1. Are you now married?  YES  NO If Yes, what is your husband's name? \_\_\_\_\_ (FIRST, MIDDLE, LAST)

What is his address? \_\_\_\_\_

PRESENT MARRIAGE LICENSE SECURED IN (CITY, COUNTY, STATE)

PLACE OF MARRIAGE (CITY, COUNTY, STATE)	DATE OF MARRIAGE (MO, DAY, YR)
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\* NOTE: It is important that you notify the California Department of Social Services of any changes in your permanent mailing address.

2. Have you had any other marriages?  Yes  No If yes, then answer the following item:

NAME OF FORMER SPOUSE	WHERE MARRIAGE LICENSE ISSUED	DATE & PLACE OF MARRIAGE	DATE & PLACE OF DIVORCE	IF SPOUSE IS DECEASED, INDICATE DATE & PLACE OF DEATH	NO. OF CHILDREN BORN OF THE MARRIAGE
1.					
2.					
3.					

**E. OTHER CHILDREN:**

Do you have other children in addition to the child being adopted? .....  Yes  No

If Yes, complete the following item.

NAME OF CHILD	GENDER		CHECK (✓) IF BLOOD RELATED TO ADOPTEE FULL	CHILD'S DATE OF BIRTH	WHO IS TAKING CARE OF THIS CHILD? (Specify caretaker's relation to child)
	M	F			
1.					
2.					
3.					
4.					

**F. AMERICAN INDIAN ANCESTRY:**

Does anyone in your family on your mother or father's side have any American Indian ancestry? .....  Yes  No

If yes, then complete the appropriate form (JV-135/ADOPT-226)

If yes, what tribe(s)..... . What is the location of the tribe(s)..... .

Are you or your parents presently registered with the tribe or have any other ancestors ever been registered with the tribe?  Yes  No

If yes, what is your or their enrollment number(s)..... .

Have you, your parents, grandparents or any other ancestor ever had a Certificate of Degree of Indian Blood (CDIB)?  Yes  No

If yes, please attach a copy of the CDIB to this questionnaire.

**G. PSYCHOLOGICAL COUNSELING:**

Have you ever gone to a psychologist, psychiatrist, clinical social worker, mental health or behavioral health therapist for any emotional or psychological or behavioral problems you may have had?.....  Yes  No

If Yes, complete the following items.

DATE(S) AND REASONS FOR TREATMENT:

\_\_\_\_\_

NAME OF THERAPIST AND/OR AGENCY THAT PROVIDED TREATMENT:

LOCATION:

INDICATE MEDICATIONS PRESCRIBED DURING YOUR TREATMENT:

\_\_\_\_\_

REASON FOR DISCONTINUANCE IF NO LONGER UNDER TREATMENT:

\_\_\_\_\_

**H. ADOPTION QUESTIONS: (For Independent Adoptions Only)**

1. Are you represented by your own attorney during this adoption?.....  Yes  No

2. Is your attorney also the attorney for the adopting parents? .....  Yes  No  Unknown

3. How were the expenses for this pregnancy, prenatal care, and delivery paid?.....

4. Did the adopting parents pay any of your living expenses?.....  Yes  No

How much? \_\_\_\_\_

5. California Adoption Law states that birthparents who place a child for adoption must have personal knowledge of the following information about the prospective adoptive parents: their full legal name; age; religion; race or ethnicity; length of current marriage and number of previous marriages; employment; whether other children or adults live in their home; whether there are other children who do not reside in their home and the child support obligation for these children and any failure to meet these obligations; any health conditions that may shorten their life expectancy, or curtail their normal daily activities; any convictions for crimes other than minor traffic violation; any removals of children from their care due to child abuse or neglect; and their general area of residence, or if requested, their address.

6. Do you have at least this information about the adopting parents? .....  Yes  No

7. What additional information do you want or need about the adopting parents? \_\_\_\_\_

8. Have you met the adopting parents? .....  Yes  No

9. If Yes, how well acquainted are you with them? \_\_\_\_\_

SIGNATURE OF BIRTH MOTHER

DATE FORM COMPLETED

The above information was provided by: (Check applicable box)

Birth mother  Birth father  Other (explain)

CHILD'S NAME:	CASE NUMBER:
CASE WORKER'S NAME:	AGENCY'S NAME:

**SECTION II — NON IDENTIFYING INFORMATION ABOUT BIRTH MOTHER**

This information will be given to the adopting parents and will be available to your child. Please answer all questions as completely as possible.

**PART I — CHARACTERISTICS OF BIRTH MOTHER AT TIME OF ADOPTEE'S BIRTH**

**A. GENERAL INFORMATION AND PHYSICAL DESCRIPTION:**

HEIGHT	USUAL WEIGHT	EYE COLOR	SKIN COLOR	NATURAL HAIR COLOR	NATURAL HAIR TEXTURE (CHECK ALL THAT APPLY)
					<input type="checkbox"/> FINE <input type="checkbox"/> MEDIUM <input type="checkbox"/> COARSE <input type="checkbox"/> STRAIGHT <input type="checkbox"/> WAVY <input type="checkbox"/> CURLY <input type="checkbox"/> BALDING
BIRTHDATE (YEAR ONLY)	BIRTHPLACE (STATE ONLY)	BLOOD TYPE	RH Factor	BODY TYPE	ARE YOU RIGHT HANDED? <input type="checkbox"/>
				<input type="checkbox"/> SMALL BONED <input type="checkbox"/> MEDIUM BONED <input type="checkbox"/> LARGE BONED	LEFT HANDED? <input type="checkbox"/>

Race/Ethnic Group

White     Hispanic     Filipino     Black     Asian or Pacific Islander  
 American Indian or Alaskan Native     Other    (Specify) \_\_\_\_\_

If American Indian or Alaskan Native, please specify name of tribe and degree of Indian blood (if known) \_\_\_\_\_

SPECIFIC NATIONALITY DESCENT (EXAMPLE: IRISH, FRENCH, GERMAN, CANTONESE, MEXICAN, NIGERIAN)

**B. EDUCATION:**

LAST GRADE COMPLETED	PRESENTLY IN SCHOOL? <input type="checkbox"/> YES <input type="checkbox"/> NO	USUAL GRADES IN SCHOOL	OTHER TRAINING
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EXTRA CURRICULAR ACTIVITIES

SUBJECTS INTERESTED IN

**C. OCCUPATION:**

PRESENT OCCUPATION	HOW LONG?	USUAL OCCUPATION?
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WHAT ARE YOUR OCCUPATIONAL GOALS? (EXAMPLE: TO BE A TEACHER, WELDER, SALES CLERK)

**D. PERSONALITY:**

DESCRIBE YOUR PERSONALITY IN TERMS OF YOUR USUAL BEHAVIOR, ATTITUDES, MOODS, ACTIVITIES YOU USUALLY PARTICIPATE IN, TYPES OF PEOPLE YOU ENJOY BEING WITH, ETC.

DESCRIBE TALENTS, HOBBIES AND GOALS IN LIFE.

DESCRIBE HOW YOU WERE AS A CHILD.



**F. BIRTH MOTHER'S MENSTRUAL HISTORY AND PREGNANCY HISTORY OF CHILD:**

<b>1. MENSTRUAL HISTORY</b>	HOW OLD WERE YOU WHEN YOU BEGAN TO MENSTRUATE?	WHAT IS THE USUAL LENGTH OF YOUR PERIOD?	ARE YOU REGULAR? <input type="checkbox"/> YES <input type="checkbox"/> NO	NO. OF DAYS IN CYCLE
DO YOU HAVE ANY PROBLEMS WITH YOUR PERIODS? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> IF YES, EXPLAIN			WERE YOU A "DES BABY"? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN	

<b>2. THIS PREGNANCY:</b>	NAME AND ADDRESS OF OBSTETRICIAN WHO PROVIDED YOU WITH PRENATAL CARE			
	NAME OF OBSTETRICIAN	ADDRESS	STREET	CITY, STATE ZIP CODE
WHEN DID PRENATAL CARE BEGIN?	WHAT WAS YOUR AGE WHEN YOU BECAME PREGNANT?	NUMBER OF WEEKS OF THIS PREGNANCY?	TYPE OF BIRTH <input type="checkbox"/> SINGLE <input type="checkbox"/> MULTIPLE <input type="checkbox"/> IF MULTIPLE, HOW MANY?	
COMPLICATIONS DURING THIS PREGNANCY? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> IF YES, EXPLAIN			HAVE YOU GIVEN BIRTH TO ANY OTHER CHILDREN? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> IF YES, HOW MANY	

<b>3. CONDITIONS DURING THIS PREGNANCY</b>	SEXUALLY TRANSMITTED DISEASES			
	GERMAN MEASLES ..... <input type="checkbox"/> YES <input type="checkbox"/> NO	HERPES <input type="checkbox"/> GONORRHEA <input type="checkbox"/> SYPHILIS	VIRUS (e.g., flu) ..... <input type="checkbox"/> YES <input type="checkbox"/> NO	
	INFECTIONS ..... <input type="checkbox"/> YES <input type="checkbox"/> NO	CHLAMYDIA <input type="checkbox"/> GENITAL WARTS	ACCIDENTS ..... <input type="checkbox"/> YES <input type="checkbox"/> NO	
IF YES TO ANY OF THE ABOVE, SPECIFY TYPE OF CONDITION(S), DATE(S) AND TYPE OF TREATMENT				

**4. DRUGS TAKEN DURING, AND WITHIN ONE YEAR PRIOR, TO THIS PREGNANCY:**

a. <b>Prescription Drugs:</b> [Give name(s)]	TAKEN DURING THIS PREGNANCY <i>(Check ✓ under appropriate column)</i>		TAKEN WITHIN ONE YEAR PRIOR TO PREGNANCY		WHEN?	HOW OFTEN?	AMOUNT?
	YES	NO	YES	NO			
1.							
2.							
3.							
4.							
<b>b. Nonprescription Drugs. Including aspirin, nosedrops, etc.</b>							
1.							
2.							
3.							
4.							
<b>c. Alcohol and other substances:</b>							
1. Alcohol (wine, beer, etc.).....							
2. Amphetamines (uppers).....							
3. Barbiturates (downers).....							
4. Tobacco .....							
5. Cocaine .....							
6. Crack.....							
7. Heroin.....							
8. LSD .....							
9. PCP .....							
10. Marijuana .....							
11. Other (specify).....							

Have you ever been an IV drug user?  YES  NO

**G. PERSONAL HEALTH HISTORY:**

DESCRIBE YOUR GENERAL HEALTH

WHAT CHILDHOOD DISEASES HAVE YOU HAD?

- MEASLES:  RUBELLA (3 DAY)  MUMPS  HAYFEVER  EAR INFECTIONS  EAR RHEUMATIC FEVER  RHEUMATIC FEVER  
 RUBEOLA (2 WEEK)  CHICKEN POX  ROSEOLA  ENCEPHALITIS  HEART MURMUR  URINARY/BLADDER INFECTIONS  
 ASTHMA  MENINGITIS  SCARLET FEVER  OTHER (Specify)

ANY MAJOR SURGERY?

- YES  NO IF YES, FOR WHAT CONDITIONS/and when?

ARE YOU A

- TWIN  TRIPLET  OTHER MULTIPLE BIRTH

ARE YOU AN

- IDENTICAL OR  FRATERNAL TWIN

**H. FAMILY HISTORY:**

WERE YOU OR ANY MEMBER OF YOUR IMMEDIATE FAMILY ADOPTED?

- YES  NO IF YES, PLEASE TELL WHO

	YOUR BIOLOGICAL FATHER		YOUR BIOLOGICAL MOTHER	
	HEIGHT	WEIGHT	HEIGHT	WEIGHT
Current age .....				
If deceased, age at death .....				
Cause of death .....				
Height & Weight .....	HEIGHT	WEIGHT	HEIGHT	WEIGHT
Hair color and texture .....				
Eye color .....				
Skin color .....				
Left or right handed .....				
Outstanding features .....				
Education completed .....				
Occupation .....				
Race/Ethnic Group .....	<input type="checkbox"/> WHITE <input type="checkbox"/> HISPANIC <input type="checkbox"/> BLACK <input type="checkbox"/> FILIPINO <input type="checkbox"/> ASIAN OR PACIFIC ISLANDER <input type="checkbox"/> OTHER (Specify) <input type="checkbox"/> AMERICAN INDIAN OR ALASKAN NATIVE		<input type="checkbox"/> WHITE <input type="checkbox"/> HISPANIC <input type="checkbox"/> BLACK <input type="checkbox"/> FILIPINO <input type="checkbox"/> ASIAN OR PACIFIC ISLANDER <input type="checkbox"/> OTHER (Specify) <input type="checkbox"/> AMERICAN INDIAN OR ALASKAN NATIVE	
Nationality .....				
Religion .....				
Was this parent aware of your pregnancy? .....	<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	
How many brothers or sisters did she/he have? .....				
If any of your aunts or uncles have died, give age at death and cause of death .....				
	YOUR FATHER'S PARENTS		YOUR MOTHER'S PARENTS	
	FATHER	MOTHER	FATHER	MOTHER
Age .....				
If deceased, age at death and cause of death .....				
Describe physical appearance				
Height & Weight .....	HEIGHT	WEIGHT	HEIGHT	WEIGHT
Outstanding features .....				
Education completed .....				
Current or former occupation				
Was he/she aware of your pregnancy? .....	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

**H. FAMILY HISTORY: (CONTINUED)**

**YOUR BROTHERS AND SISTERS**

*(If you have more than 4 siblings, please use additional paper)*

	1		2		3		4	
Gender (Male or Female) .....								
Age .....								
If deceased, age at death and cause .....								
Full or half sibling to you? .....	<input type="checkbox"/> FULL	<input type="checkbox"/> HALF						
Height & Weight.....	HEIGHT	WEIGHT	HEIGHT	WEIGHT	HEIGHT	WEIGHT	HEIGHT	WEIGHT
Hair color and texture .....								
Eye color.....								
Skin color.....								
Hobbies and talents.....								
Last grade completed .....								
Presently in school? .....	<input type="checkbox"/> YES	<input type="checkbox"/> NO						
Occupation .....								
Aware of Pregnancy? .....	<input type="checkbox"/> YES	<input type="checkbox"/> NO						
Marital status .....								
Number of children they have .....								
Health of their children.....								

**YOUR OTHER CHILDREN**

*(If you have more than 4 children, please use additional paper)*

	CHILD #1		CHILD #2		CHILD #3		CHILD #4	
Indicate if son or daughter .....								
Birthdate or age.....								
Is this child a full or half sibling to the adoptee?.....	<input type="checkbox"/> FULL	<input type="checkbox"/> HALF						
If deceased, age at death .....								
Cause of death .....								
Height & Weight.....	HEIGHT	WEIGHT	HEIGHT	WEIGHT	HEIGHT	WEIGHT	HEIGHT	WEIGHT
Hair color and texture .....								
Eye color.....								
Skin color.....								
Left or right handed .....								
Grade in school.....								
Does this child live with you? .....	<input type="checkbox"/> YES	<input type="checkbox"/> NO						
Hobbies and talents.....								
General health .....								
Major surgery.....								
Health problems.....								
Was this child aware of the pregnancy?.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO						

## I. HEALTH HISTORY OF YOU, YOUR PARENTS AND OTHER RELATIVES

Indicate by checking appropriate box if YOU or any RELATIVES (i.e., your parents, sisters, brothers, aunts, uncles, grandparents, other children born to you, etc.) have had or now have the medical conditions listed below. Indicate person's relationship to you. Please complete Comments Section. If a medical condition resulted in death of a family member, indicate this and the person's approximate age at time of death in Comments Sections.

MEDICAL CONDITION	NO	Not Known	YES Self	YES - RELATIVE (Specify relationship)	COMMENTS
<b>A. CONGENITAL IMPAIRMENTS</b>					
1. Clubfoot or any orthopedic problem (i.e., flat footed, etc.)					
2. Harelip (cleft lip) or cleft palate					
3. Down's Syndrome					
4. Other Chromosome abnormality					
5. Hydrocephalus					
6. Muscular dystrophy					Parts of body involved? Age at onset?
7. Dwarfism					
8. Spina bifida					
9. Congenital heart defect					
10. Sickle Cell Anemia					
11. Tay-Sachs disease					
<b>B. ALLERGIES</b>					To what allergies? What treatment or medication?
1. Eczema or other skin condition					
2. Hay fever or other allergy					
3. Drug allergy					To what drugs?
4. Food allergy					To what foods?
<b>C. EYE, DENTAL, EAR, AND DEVELOPMENTAL DISORDERS</b>					
1. Blindness, glaucoma, color blindness or other visual problems					
2. Corrective glasses or contact lenses					At what age were prescription lenses necessary?
Nearsighted <input type="checkbox"/>					
Farsighted <input type="checkbox"/>					
Astigmatism (inability to focus) <input type="checkbox"/>					
Strabismus (crosseye) <input type="checkbox"/>					
Other (explain) <input type="checkbox"/>					
3. Braces on teeth or other orthodontia work					If so, what orthodontic work and for how long?

**I. HEALTH HISTORY OF YOU, YOUR PARENTS AND OTHER RELATIVES (Continued)**

MEDICAL CONDITION	NO	Not Known	YES Self	YES - RELATIVE <i>(Specify relationship)</i>	COMMENTS
4. Deafness or other ear problems					Special education? If "Yes", indicate age at onset.
5. Speech problems					
6. Learning disability					
7. Retardation: mental or physical					Any diagnosis? Hospitalization?
<b>D. CIRCULATORY DISORDERS</b>					
1. Hemophilia					
2. Sickle cell anemia or trait					
3. Hypertension (high blood pressure)					Age at onset? What treatment? Hospitalization?
4. Stroke					
5. Heart attack (coronary)					
6. Arthritis					What kind? Age at onset? What part of body?
7. Kidney disease					Age at onset? What treatment?
<b>E. HORMONAL DISORDERS</b>					Age at onset? What treatment?
1. Diabetes					
2. Thyroid disorder					
3. Obesity (overweight)					
<b>F. RESPIRATORY DISORDERS</b>					Any (known) cause? What treatment?
1. Asthma					
2. Emphysema					Age at onset?
3. Tuberculosis					Age at onset? What kind? What part of body?
<b>G. MENTAL AND BEHAVIORAL DISORDERS</b>					Age at onset? What treatment? Hospitalization?
1. Diagnosed schizophrenia					
2. Diagnosed manic depressive					
3. Other mental illness. Describe, using additional page, if necessary					
4. Alcoholism or heavy drinking					
5. Drug usage					Kind, amount, and when taken?

**I. HEALTH HISTORY OF YOU, YOUR PARENTS AND OTHER RELATIVES (Continued)**

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