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? ☐ YES ☐ NO ☐ UNKNOWN	DOES YOUR FATHER KNOW OF THIS ADOPTION? ☐ YES ☐ NO ☐ UNKNOWN
IF IN THE FUTURE WE NEED TO LOCATE YOU, MAY WE CONTACT YOUR MOTHER FOR ASSISTANCE? ☐ YES ☐ NO	IF IN THE FUTURE WE NEED TO LOCATE YOU, MAY WE CONTACT YOUR FATHER FOR ASSISTANCE? ☐ YES ☐ 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)

* 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 M	GENDER F	CHECK (✓) IF BLOOD RELATED TO ADOPTEE FULL	CHECK (✓) IF BLOOD RELATED TO ADOPTEE HALF	CHILD'S DATE OF BIRTH	WHO IS TAKING CARE OF THIS CHILD? *(Specify caretaker's relation to child)*
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)
					☐ FINE ☐ MEDIUM ☐ COARSE ☐ STRAIGHT ☐ WAVY ☐ CURLY ☐ BALDING

BIRTHDATE (YEAR ONLY)	BIRTHPLACE (STATE ONLY)	BLOOD TYPE	RH Factor	BODY TYPE	ARE YOU RIGHT HANDED? ☐ LEFT HANDED? ☐
				☐ SMALL BONED ☐ MEDIUM BONED ☐ LARGE BONED	

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?	USUAL GRADES IN SCHOOL	OTHER TRAINING
	☐ YES ☐ NO		

EXTRA CURRICULAR ACTIVITIES

SUBJECTS INTERESTED IN

C. OCCUPATION:

PRESENT OCCUPATION	HOW LONG?	USUAL OCCUPATION?

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.

E. ADOPTION QUESTIONS:

Religion:

What Religion do you practice? _____

ARE YOU WILLING TO HAVE YOUR CHILD REARED IN THE RELIGIOUS FAITH OF THE ADOPTING PARENTS, IF DIFFERENT FROM YOUR OWN? ☐ YES ☐ NO

IF NO, WHAT RELIGIOUS FAITH DO YOU WISH YOUR CHILD TO BE RAISED? _____

WHY DID YOU PLACE THIS CHILD FOR ADOPTION? (PLEASE RESPOND AS THOROUGHLY AS YOU CAN. THIS IS THE QUESTION ADULT ADOPTEES MOST OFTEN ASK ADOPTION AGENCIES.)

IF YOUR CHILD WAS NOT PLACED FOR ADOPTION AT BIRTH, GIVE INFORMATION ON THE CHILD'S CARE, HEALTH AND DEVELOPMENT BEFORE PLACEMENT.

HOW DO YOU FEEL ABOUT BEING CONTACTED BY THE ADOPTEE WHEN HE OR SHE REACHES ADULTHOOD?

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

1. MENSTRUAL HISTORY

HOW OLD WERE YOU WHEN YOU BEGAN TO MENSTRUATE?	WHAT IS THE USUAL LENGTH OF YOUR PERIOD?	ARE YOU REGULAR? ☐ YES ☐ NO	NO. OF DAYS IN CYCLE

DO YOU HAVE ANY PROBLEMS WITH YOUR PERIODS?
☐ YES ☐ NO ☐ IF YES, EXPLAIN

WERE YOU A "DES BABY"?
☐ YES ☐ NO ☐ UNKNOWN

2. THIS PREGNANCY:

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 ☐ SINGLE ☐ MULTIPLE ☐ IF MULTIPLE, HOW MANY?

COMPLICATIONS DURING THIS PREGNANCY?
☐ YES ☐ NO ☐ IF YES, EXPLAIN

HAVE YOU GIVEN BIRTH TO ANY OTHER CHILDREN?
☐ YES ☐ NO ☐ IF YES, HOW MANY

3. CONDITIONS DURING THIS PREGNANCY

GERMAN MEASLES ..... ☐ YES ☐ NO
INFECTIONS ..... ☐ YES ☐ NO

SEXUALLY TRANSMITTED DISEASES
☐ HERPES ☐ GONORRHEA ☐ SYPHILIS
☐ CHLAMYDIA ☐ GENITAL WARTS

VIRUS (e.g., flu) ..... ☐ YES ☐ NO
ACCIDENTS ..... ☐ YES ☐ 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. Prescription Drugs: [Give name(s)]	**TAKEN DURING THIS PREGNANCY** *(Check ✔ under appropriate column)*		**TAKEN WITHIN ONE YEAR PRIOR TO PREGNANCY**		**WHEN?**	**HOW OFTEN?**	**AMOUNT?**
	YES	**NO**	**YES**	**NO**			
1.	☐	☐	☐	☐			
2.	☐	☐	☐	☐			
3.	☐	☐	☐	☐			
4.	☐	☐	☐	☐			
b. Nonprescription Drugs. Including aspirin, nosedrops, etc.							
1.	☐	☐	☐	☐			
2.	☐	☐	☐	☐			
3.	☐	☐	☐	☐			
4.	☐	☐	☐	☐			
c. Alcohol and other substances:							
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) ☐ RUBEOLA (2 WEEK) ☐ MUMPS ☐ CHICKEN POX ☐ HAYFEVER ☐ ROSEOLA ☐ ASTHMA ☐ EAR INFECTIONS ☐ ENCEPHALITIS ☐ MENINGITIS ☐ EAR RHEUMATIC FEVER ☐ HEART MURMUR ☐ SCARLET FEVER ☐ RHEUMATIC FEVER ☐ URINARY/BLADDER INFECTIONS ☐ 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
Current age		
If deceased, age at death		
Cause of death		
Height & Weight	WEIGHT	HEIGHT / WEIGHT
Hair color and texture		
Eye color		
Skin color		
Left or right handed		
Outstanding features		
Education completed		
Occupation		
Race/Ethnic Group	☐ WHITE ☐ HISPANIC ☐ BLACK ☐ FILIPINO ☐ ASIAN OR PACIFIC ISLANDER ☐ OTHER (Specify) ☐ AMERICAN INDIAN OR ALASKAN NATIVE	☐ WHITE ☐ HISPANIC ☐ BLACK ☐ FILIPINO ☐ ASIAN OR PACIFIC ISLANDER ☐ OTHER (Specify) ☐ AMERICAN INDIAN OR ALASKAN NATIVE
Nationality		
Religion		
Was this parent aware of your pregnancy?	☐ YES ☐ NO	☐ YES ☐ 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	HEIGHT / WEIGHT	HEIGHT / WEIGHT
Outstanding features				
Education completed				
Current or former occupation				
Was he/she aware of your pregnancy?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ 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?	☐ FULL ☐ HALF	☐ FULL ☐ HALF	☐ FULL ☐ HALF	☐ FULL ☐ 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?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Occupation				
Aware of Pregnancy?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ 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?	☐ FULL ☐ HALF	☐ FULL ☐ HALF	☐ FULL ☐ HALF	☐ FULL ☐ 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?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Hobbies and talents				
General health				
Major surgery				
Health problems				
Was this child aware of the pregnancy?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ 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
A. CONGENITAL IMPAIRMENTS 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. ALLERGIES 1. Eczema or other skin condition					To what allergies? What treatment or medication?
2. Hay fever or other allergy					
3. Drug allergy					To what drugs?
4. Food allergy					To what foods?
C. EYE, DENTAL, EAR, AND DEVELOPMENTAL DISORDERS 1. Blindness, glaucoma, color blindness or other visual problems					
2. Corrective glasses or contact lenses					At what age were prescription lenses necessary?
Nearsighted ☐ Farsighted ☐					
Astigmatism (inability to focus) ☐					
Strabismus (crosseye) ☐					
Other (explain) ☐					
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 *(Specify relationship)*	COMMENTS
4. Deafness or other ear problems					Special education? If "Yes", indicate age at onset.
5. Speech problems					
6. Learning disability					Any diagnosis? Hospitalization?
7. Retardation: mental or physical					
D. CIRCULATORY DISORDERS 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?
E. HORMONAL DISORDERS 1. Diabetes					Age at onset? What treatment?
2. Thyroid disorder					
3. Obesity (overweight)					
F. RESPIRATORY DISORDERS 1. Asthma					Any (known) cause? What treatment?
2. Emphysema					Age at onset?
3. Tuberculosis					Age at onset? What kind? What part of body?
G. MENTAL AND BEHAVIORAL DISORDERS 1. Diagnosed schizophrenia					Age at onset? What treatment? Hospitalization?
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 *(Specify relationship)*	COMMENTS
H. LYMPHATIC DISORDERS					What kind? Age at onset? What part of body?
1. Cancer					
2. Tumors					
3. Cystic fibrosis					
4. Hodgkins disease					
I. NERVOUS SYSTEM DISORDERS					Parts of body involved? Age at onset?
1. Multiple sclerosis					
2. Huntington's disease					
3. Cerebral palsy					
4. Seizures or convulsions					Age at onset? What treatment? Frequency?
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 MEDICAL OR HEALTH PROBLEMS					