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 released to your adopted child or his/her adoptive parent(s) unless you give us written permission to release it. Section II consists of "nonidentifying" information. California adoption law requires that a copy of Section II, which contains medical, psychological and social information, be released to your child's adoptive parent(s) before the finalization of the adoption and upon written request from your adopted child when he/she reaches age 18.
- All information requested on this form is important for the completion of your child's adoption.

SECTION I — IDENTIFYING INFORMATION ABOUT BIRTH MOTHER

This information will be kept confidential unless you give written permission to release it.

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 BIRTH MOTHER'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 ( )
LAST KNOWN ADDRESS (STREET, CITY, STATE, COUNTRY IF OUTSIDE U.S.A.)	

Have you and the child's birth father ever attempted to marry? ☐ YES ☐ NO

If yes, explain _____

D. MARITAL HISTORY

1. Are you now married? ☐ YES ☐ NO If yes, what is your spouse's name? _____ (FIRST, MIDDLE, LAST)

   What is his/her address? _____

PLACE OF PRESENT MARRIAGE (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, answer the following:

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.					
4.					

E. OTHER CHILDREN

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

If yes, complete the following:

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.						
5.						

F. AMERICAN INDIAN ANCESTRY (ICWA-020 FORM MUST BE COMPLETED)

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

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:

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. Is an attorney representing you during this adoption? ☐ Yes ☐ No
2. Is your attorney also representing the adopting parent(s)? ☐ Yes ☐ No ☐ Unknown
3. Who paid the expenses for this pregnancy, including prenatal care, delivery and any other expenses?_____
4. Did the adopting parent(s) pay for any of your living expenses? ☐ Yes ☐ No
   How much did they pay? $_____
5. California adoption law states that birth parents who place a child for adoption must have personal knowledge about the adopting parent(s). Please indicate whether you have any of the following information about the adopting parent(s):
   - Full legal name ☐ Yes ☐ No
   - Age ☐ Yes ☐ No
   - Religion ☐ Yes ☐ No
   - Race or ethnicity ☐ Yes ☐ No
   - Length of current marriage ☐ Yes ☐ No
   - Number of previous marriages ☐ Yes ☐ No
   - General area of residence (if requested, their address) ☐ Yes ☐ No
   - Employment ☐ Yes ☐ No
   - Whether other children or adults live in their home ☐ Yes ☐ No
   - Children who do not live in their home ☐ Yes ☐ No
   - Any child support obligation for these children? ☐ Yes ☐ No
   - Any failure to meet child support obligation? ☐ Yes ☐ No
   - Health conditions restricting normal daily activities or reducing normal life expectancy? ☐ Yes ☐ No
   - Any history of arrest and convictions for any crimes other than traffic violations? ☐ Yes ☐ No
   - Any removal of children from care due to child abuse or neglect? ☐ Yes ☐ No
6. What additional information do you want or need about the adopting parent(s)?_____
7. Have you met the adopting parent(s)? ☐ Yes ☐ No
8. 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 released to the adopting parent(s) and will be available to your child. Please answer all questions as completely as possible.

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? ☐ YES ☐ NO	USUAL GRADES IN SCHOOL	OTHER TRAINING

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

WHAT IS YOUR RELIGION? _____

ARE YOU WILLING TO HAVE YOUR CHILD REARED IN THE RELIGIOUS FAITH OF THE ADOPTING PARENT(S), 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

2. THIS PREGNANCY

NAME AND ADDRESS OF OBSTETRICIAN WHO PROVIDED YOU WITH PRENATAL CARE

NAME OF OBSTETRICIAN _____ ADDRESS _____

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) YES	TAKEN DURING THIS PREGNANCY NO	TAKEN WITHIN ONE YEAR PRIOR TO PREGNANCY YES	TAKEN WITHIN ONE YEAR PRIOR TO PREGNANCY NO	WHEN?	HOW OFTEN?	AMOUNT?
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 ☐ RHEUMATIC FEVER ☐ HEART MURMUR ☐ SCARLET FEVER ☐ WHOOPING COUGH ☐ 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 INDICATE WHO _____

	YOUR BIOLOGICAL FATHER	YOUR BIOLOGICAL MOTHER
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	☐ 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 the 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" section.

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? What 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. Developmental disability					
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 cause known? 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 bi-polar					
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:					