707 Broadway NE, Suite 103, Albuquerque, N.M. 87102

Phone: (505) 766-9361
Fax: (505) 766-9157

BIRTHMOTHER INFORMATION: This form is very important, because it will help us get to know you so that we may help you find the right adoptive parents for your child. Please use a pen to complete this form. Do not leave any questions unanswered; you can write "don't know" or "unknown" where you are unable to provide an answer. Please attach a current photo and return to La Familia, Inc. Thank you.

Your Name: ____

Your Maiden Name or any other names you've used: ____________________________

Address: ____

Telephone: (Home) ______________ (Work)_____________________________________

Your Age: _______________ Your Due Date: _____________________________

Your Birthdate: _________________ Your Birthplace: ______________________

Your Height: _______ Weight before pregnancy: _______ Weight now: ____________

Natural Hair Color: ________ Hair Color Now: _________ Eye Color: _____________

Complexion: (Circle one): Fair Normal Olive Tan Dark Other:_____________

Religion: ________________ Attend Church Regularly? _________________________

Ancestry/Nationality (the country or countries from which your family originally came):

____

Race (Circle as many as apply):
Asian Hispanic Native American African-American Caucasian Other:________

If Native American, are you registered with a tribe? __________________

If yes, list tribal name and enrollment number: ___________________________

Marital Status (Circle the correct answer) Are you presently-

1. Single 2. Married 3. Separated 4. Divorced 5. Widowed 6. Other:_____

Marital History (Number of past or annulled marriages): ___________________________

Date of Divorce & state where granted, if applicable ______________________________

How many years of school did you complete? __________________________________

Present Occupation: ____

Previous Employment: ____

Hobbies, Talents, Special Interests: ____

Your Social Security Number: ____

Driver's License Number: ____________________ State: _______________________

Person to be notified in case of emergency: ____________________________________

Relationship to you: ___________________ Phone: ______________________

Any other agencies or attorney with whom you've discussed adoption planning:

____

BIRTHMOTHER'S FAMILY BACKGROUND

Is your family aware of your pregnancy: (Circle one) YES NO

Do they agree with your adoption plan? (Circle one) YES NO

Do you want our staff to withhold the agency's identity when calling for you at home?
(In such cases, staff give first names only and will not offer agency name.) YES NO

	YOUR MOTHER	YOUR FATHER
Name:	____________________	____________________
City/State:	____________________	____________________
Marital Status:	____________________	____________________
Birthdate:	____________________	____________________
Health Status:	____________________	____________________
Height:	____________________	____________________
Weight:	____________________	____________________
Eye Color:	____________________	____________________
Hair Color:	____________________	____________________
Nationality:	____________________	____________________
Race:	____________________	____________________
Education:	____________________	____________________
Occupation:	____________________	____________________
Religion:	____________________	____________________
Medical Problem:	____________________	____________________
Cause of Death:	____________________	____________________

PLEASE LIST BELOW ALL BROTHERS AND SISTERS:

	First Name	Age	Occupation	State of Residence	Health Problems
1.					
2.					

3. ____

4. ____

Are you, yourself, adopted? ____

If so, please list date and where adopted from: ______________________________

BIRTHMOTHER'S REPRODUCTIVE HISTORY

Do you have insurance coverage?______________________ Medicaid? ______________

Name of Company:____

Policy or card number:____

Is this your first pregnancy? ___if not, how many times have you been pregnant before?__

How many of the following have you had?

Live Births: ____ C-Sections:_____ Abortions: _____

Adoptions: ____ Miscarriages: _____ Stillborns: ______

Children born to birthmother prior to this pregnancy:

Name	Sex	Date of Birth	Health Problems	Birth Complications

HEALTH STATUS OF BIRTHMOTHER

Any allergies:____

Any serious illnesses, injuries, or hospitalizations:__________________________________

____

Any psychiatric hospitalizations or treatment: ____________________________________

Any past or present substance abuse problems? (Please list date, addiction and how you've handled the problem) ____

Have you experienced any of the following? Check all that apply.

______ Anxiety Panic Attacks (date/outcome: _________________________________)

______ Sleeping Problems (date/outcome:_____________________________________)

______ Depression (age/details:____)

______ Rape (date/outcome:____)

______ Incest or sexual abuse (age/details:__________________________________)

______ Physical child abuse (age/details:____________________________________)

______ Eating disorders (age/details:_______________________________________)

______ Suicide attempt(s) (date/details:_____________________________________)

______ Domestic violence/battering by partner (date/outcome:___________________)

______ Arrest/Criminal charges (date/crime/outcome:___________________________)

______ Significant losses, i.e. Death of close family member or friend, ending of valued Relationship, lost job, etc.

(Date/details/effect on you:____)

______ Problems in school (date/details:_____________________________________)

______ PMS – pre-menstrual syndrome (details:_______________________________)

______ Any other problems you wish to share (details:__________________________)

PREGNANCY HISTORY INVOLVING THIS CHILD

Is child's father a relative of yours? ______________________________________

If "yes", how is he related to you? ________________________________

What month did you begin prenatal care for this pregnancy? ________________________
How much weight have you gained so far during pregnancy? ________________________

What complications, if any, have you had during pregnancy? ________________________

Have you had any special testing during your pregnancy? Check all that apply:

______ SONOGRAM (results: ____

______ HIV/AIDS test (results: ____

______ MATERNAL SERUM/AFP test (results: ________________________________

______ VENEREAL DISEASE test (results: __________________________________

______ AMNIOCENTESIS (results: ____

______ Other (describe: ____

During this pregnancy, have you had rubella? ______________________________________

(Date if yes: ____

Have you had any venereal diseases? ____

(Date/type if yes: ____

Have you had any infections? ____

(Date/type if yes: ____

Have you had any accidents? ____

(Date and details if yes: ____

Has there been anything unusual or abnormal about your pregnancy? ________________

____

Since you became pregnant, do you smoke? ____

(If yes, list what you smoke and how much: ________________________________

Do you drink? ____

(If yes, list what you drink and how often, on the average: ____________________
____

Do you use drugs? ____

(If yes, what drugs at what stage of pregnancy: ________________
____

MEDICATION AND DRUG HISTORY:

Please indicate in the appropriate spaces below any and all medications and/or drugs taken during the pregnancy involving this child and medications and/or drugs taken during the five years before this pregnancy occurred.

	YES	NO	Month of pregnancy or year if prior to it.	Type, frequency & amount
1. Antidepressants	_____	_____	__________________	________________________
2. Antibiotics	_____	_____	__________________	________________________
3. Antihistamines	_____	_____	__________________	________________________
4. Hormones	_____	_____	__________________	________________________
5. Cortisone	_____	_____	__________________	________________________
6. Diet Pills	_____	_____	__________________	________________________
7. Sleeping Pills	_____	_____	__________________	________________________
8. Tranquillizers	_____	_____	__________________	________________________
9. Cancer Medication	_____	_____	__________________	________________________
10. Blood pressure pills	____	_____	__________________	________________________
11. Birth control pills	____	_____	__________________	________________________
12. Thalidomides	____	_____	__________________	________________________
13. Nausea medicine	____	_____	__________________	________________________

14. Seizure medication	____	____	____________	____________
15. Nose drops	____	____	____________	____________
16. Alcohol	____	____	____________	____________
17.Amphetamines/Speed	____	____	____________	____________
18. Barbiturates	____	____	____________	____________
19. Cocaine/Crack	____	____	____________	____________
20. Heroin	____	____	____________	____________
21. LSD/Acid	____	____	____________	____________
22. Marijuana	____	____	____________	____________
23. Crank	____	____	____________	____________
24. Paint/Glue Sniffing	____	____	____________	____________
25. Methadone	____	____	____________	____________
26. Antabuse	____	____	____________	____________
27. Shared Needles?	____	____	____________	____________
28. Other:	____	____	____________	____________

MEDICAL INFORMATION & GENETIC HISTORY

Check "Yes" or "No" to indicate whether YOU or any GENETIC RELATIVES (your parent, siblings, grandparents, aunts, uncles, or any other children you've had) ever had or now have any of the medical conditions listed below, and complete Detail section also so your child will have an accurate health history.

MEDICAL CONDITION	NO	Unknown (D/K)	Yes, I had/have this	RELATIVE/s who have had this illness/condition	DETAILS/TREATMENT
Vision problems or blindness Nearsighted_ Farsighted					
Hearing problems or deafness					
Speech problems					
Asthma					
Hayfever/allergies					
Alcoholism/ETOH abuse					
Seizures/convulsions and/or epilepsy					
Congenital heart defect					
Cancer (type:)					
Tumors (where:)					
Multiple Sclerosis					
Cerebral Palsy					
Muscular Dystrophy					
Learning Disability or ADHD					
Diabetes					
Thyroid disorder					
Hemophilia					
Sickle Cell Anemia					
Schizophrenia or MPD					
Bipolar depression					
Other mental illness:					
Heart attack or stroke					
Cystic Fibrosis					
Alzheimer's Disease					
Hospitalization/operation/injury					
HIV or AIDS					
Hepatitis (check one:__A __B __C					
Kidney disease					
Tuberculosis					
Hypertension (high blood pressure)					
Mental retardation					
Eczema or skin condition					
Cleft lip or cleft palate					
Other health or medical conditions					

BIRTHFATHER INFORMATION:

This information is required by law, so if the father of this child is not available to fill this out, please provide all the information possible, to the best of your knowledge. **For any item of information you do not know, you must write in "Unknown"**. (Failure to honestly identify the father of the child or his whereabouts may be considered fraud, a crime punishable by law.) Please also attach a photo, if available.

His Name: ____

Address (or last known residence): ____

Telephone: (Home) ____________________ (Work) _______________________

Birthdate: ________________ Age: _______ Birthplace: _________________

Length of relationship with birthmother: ____

Religion: ________________ Ancestry/Nationality: ________________________

Race (Circle as many as apply):
Asian Hispanic Native American African-American Caucasian Other:________

If Native American, is he registered with a tribe? __________________________

If yes, list tribal name and enrollment number: ______________________

Marital Status: (circle the correct answer) Is he presently

1. Single 2. Married 3. Separated 4. Divorced 5. Other:______________________

If deceased, date and cause of death: ____

(Please attach copy of obituary or death certificate if applicable and possible.)

PHYSICAL DESCRIPTION

Height: ________ Weight: ______ Hair Color: ______ Eye Color: _________

Complexion (Circle one): Fair Normal Olive Tan Dark Other:________________

SOCIAL HISTORY

Years of School Completed: ____

Present Occupation: __________________ Where? ______________________

Former Employment: ____

Interests, hobbies, and talents: ____

Social Security Number: ___________ Driver's License Number: _____________

Automobile: Make: ____________ Model: _______________ Year: ___________

Present or prior arrests, charges or convictions (give date and details): _______________

____

Is the baby's father aware of your pregnancy? Circle one	YES	NO
Does he agree with your adoption plan? Circle one	YES	NO
Is he financially supporting you during pregnancy? Circle one	YES	NO
Does he acknowledge that this is his child? Circle one	YES	NO
Could any other man be the father of this child? Circle on	YES	NO

(If so, provide name/s and explanation: _________________________________

____)

Children born to birthfather prior to this pregnancy:

Name	Sex	Date of Birth	Health Problems	Who has Custody?

Is he legally obligated to or voluntarily providing child support for any of the above children? YES NO

Does birthfather wish to be included in the adoption planning for this child?

YES NO

In which of the following way would the birthfather like to participate? Check all that apply.

____________ Would like to receive counseling.

____________ Would like to review adoptive family profiles at agency.

____________ Would like to have prenatal contact with adoptive family.

____________ Would like to assist in financial support of birthmother.

____________ Would like to hear from other birthfathers that've been through this

____________ Would like to sign Waiver of Notice before birth (unmarried only)

____________ Would like to meet adoptive family at placement time

____________ Would like to receive baby photos following birth

____________ Would like to write letter to be sent home with baby.

____________ Other: ____

Person to be notified in case of emergency: ____________________________________

Relationship to birth father: _____________ Phone: __________________

BIRTHFATHER’S FAMILY BACKGROUND

	MOTHER	FATHER
Name:	____________________	____________________
City/State:	____________________	____________________
Marital Status:	____________________	____________________
Birthdate:	____________________	____________________
Health Status:	____________________	____________________
Height:	____________________	____________________
Weight:	____________________	____________________
Eye Color:	____________________	____________________
Hair Color:	____________________	____________________
Nationality:	____________________	____________________
Race:	____________________	____________________
Education:	____________________	____________________
Occupation:	____________________	____________________
Religion:	____________________	____________________
Medical Problem:	____________________	____________________
Cause of Death:	____________________	____________________

PLEASE LIST BELOW ALL BROTHERS AND SISTERS:

	First Name	Age	Occupation	State of Residence	Health Problems
1.					
2.					
3.					

HEALTH STATUS OF BIRTHFATHER

Any allergies: ______________________________

Any tattoos or scars: ______________ Type/where: ______________________________

Any serious illnesses, injuries or hospitalizations: ______________________________

____

Any psychiatric hospitalizations or treatment: ______________________________

____

Any past or present substance abuse problems? (Please list date, addiction and how you've handled the problem): ______________________________

Any venereal disease: ______________________________

Does the father smoke? ______________________________

If yes, what and how much: ______________________________

Does he drink? ______________________________

If yes, what and how often, on the average: ______________________________

Does he use drugs? ______________________________

If yes, list drug(s) and how often he uses, on the average: ______________________________

MEDICAL INFORMATION & GENETIC HISTORY

Check "Yes" or "No" to indicate whether YOU or any GENETIC RELATIVES (your parents, siblings, grandparents, aunts, uncles, or any other children you've had) ever had or now have any of the medical conditions listed below, and complete Detail section also so your child will have an accurate health history.

MEDICAL CONDITION	NO	Unknown (D/K)	Yes, I had/have this	RELATIVE/s who have or had this illness/condition	DETAILS/TREATMENT
Vision problems or blindness Nearsighted Farsighted					
Hearing problems or deafness					
Speech problems					
Asthma					
Hay fever/allergies					
Alcoholism/ETOH abuse					
Seizures/convulsions and/or epilepsy					
Congenital heart defect					
Cancer (type:)					
Tumors (where)					
Multiple Sclerosis					
Cerebral Palsy					
Muscular Dystrophy					
Learning Disability or ADHD					
Diabetes					
Thyroid disorder					
Hemophilia					
Sickle Cell Anemia					
Schizophrenia or MPD					
Bipolar depression					
Other mental illness:					
Heart attack or stroke					
Cystic Fibrosis					
Alzheimer's Disease					
Hospitalization/operation/injury					
HIV or AIDS					
Hepatitis (check one:__A__B __C					
Kidney disease					
Tuberculosis					
Hypertension (high blood pressure)					
Mental Retardation					

Eczema or skin condition					
Cleft lip or cleft palate					
Other health or medical condition					

COUNSELING DEPARTMENT-CONFIDENTIAL

Birthmother's name: ____

Due date: ______________ Age: ______ Phone: ________________

1. How did you and the birthfather meet? What attracted you to him?

____

____

____

____

2. How did you find out about La Familia? What made you decide to work with La Familia?

____

____

____

____

3. What is going on in your life that leads you to make this adoption plan for your child?

____

____

____

____

4. What other plans have you considered besides adoption?

____

____

5. Do you have other children? If so, in what ways do they affect this decision?

____

____

____

____

6. Why are you choosing an option other than abortion?

____

____

____

____

7. Why are you unprepared to parent this child at this time in your life?

____

____

____

____

8. Who is involved in your adoption decision? Who are the most supportive people in your life on whom you can depend during this time?

____

____

____

____

9. What are your biggest questions or fears about adoption or what you are going through these days?

____

____

____

____

10. Have you ever talked things out with a counselor before? Was it a positive or negative experience, and why?

____

____

____

____

11. At this point, what could make you change your mind about adoption?

____

____

____

____

12. What kind of relationship would you like to have with the adoptive parents, during pregnancy?

____

____

____

13. What kind of contact, if any, would you like with the adoptive family afterwards?

____

____

____

____

14. What are your personal goals or dreams? What would you like to do with your life after this pregnancy?

____

____

____

____

I HEARBY SWEAR THAT THE INFORMATION PROVIDED ON EACH PAGE OF THIS PROFILE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE, AND THAT I HAVE PROVIDED ALL AVAILABLE INFORMATION ABOUT THE IDENTITY, WHEREABOUTS AND HISTORY OF THE FATHER.

SIGNED:_______________________________________DATE:____________________