Biological Mother's Social History

STAGE I

(please print using blue or black ink)

v11.01.02 Inet

Today's Date:	Due Date: or Weeks Along:
Full Name (First, Middle, Last & Maiden)	Maiden:
Permanent Address (No PO Boxes)	
City, State, Zip	
County/Parish	
Social Security Number	
Home/Mobile Phone (w/area code)	Can we leave identifying messages? Yes ☐ No ☐ Best time to reach you? _____
Work Phone (w/area code)	Can we contact you at work? Yes ☐ No ☐
Email Address	Can we contact you by email? Yes ☐ No ☐
Birth Date/ Place of Birth	
Driver's License (State and Number)	
Your Race	☐ Caucasian ☐ African-American ☐ Hispanic ☐ Native American ☐ Asian ☐ Other _____ (check all that apply)
Heritage (example, you may be Caucasian with Irish/Italian heritage)	
Indian Heritage	Yes ☐ No ☐ If yes, name of tribe _____
Occupation	
Marital Status	☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Other If Married, to whom :
Previous Marriages	
If Divorced (Date, County & State Finalized)	
U.S. Citizen	☐ Yes ☐ No If no, passport/visa # _____

PREGNANCY AND ADOPTION DECISION

Who do you currently live with and are they supportive of your adoption plans? _____

_____

Relationship Between Biological Parents

Do you know the identity of the biological father? Yes ☐ No ☐

Do you know where the biological father is now? Yes ☐ No ☐

If yes, is he also the father of any prior child(ren)? Yes ☐ No ☐

Does he know about the pregnancy? Yes ☐ No ☐

Does he know of your adoption plan? Yes ☐ No ☐

Does he agree with your adoption plans? Yes ☐ No ☐

Will he sign papers to place the child for adoption? Yes ☐ No ☐

If no or unknown, please explain? _____

_____

If applicable, describe your current relationship with the biological father. If you are no longer together, please state when the relationship terminated.

_____

_____

PREGNANCY INFORMATION/OLDER CHILD TO BE ADOPTED

When is your due date or child's birth date? _____

What is the race of your baby? (check all that apply)

☐ Caucasian ☐ African-American ☐ Hispanic

☐ Native American ☐ Asian ☐ Other _____

LABOR AND DELIVERY INFORMATION

Are you seeing a doctor during your pregnancy? Yes ☐ No ☐

If yes, Doctor/Office/Contact Person_____

Address: _____

Phone w/ area code: _____ Fax _____

If applicable, what month of your pregnancy did you begin prenatal care? _____

MEDICAID INFORMATION

Do you have state issued Medicaid? Yes ☐ No ☐

If no, are you willing to apply? Yes ☐ No ☐

If yes, Medicaid number: #_____

Medicaid Worker's name and phone number: _____

State Medicaid was issued in: _____

****Please provide a copy of your current Medicaid card****

INSURANCE INFORMATION

Do you have private medical insurance coverage? Yes ☐ No ☐

If yes, what carrier? (i.e., United Healthcare, Blue Cross Blue Shield, etc.)

Name _____

Address _____

Phone Number _____ Policy Number _____

Percentage of bills covered (i.e., 50%, 80%)? _____

****Please provide a copy of your current insurance card****

NATIVE AMERICAN-INDIAN TRIBAL MEMBERSHIP

It is important for us to know if you are a member of any Native American Indian tribe. Please answer the following questions to the best of your knowledge.

Do you have any Indian heritage in your background? Yes ☐ No ☐

Are you, or your family, a member of any Native American Indian tribe? Yes ☐ No ☐

If yes to either one of these questions, please indicate the tribe, location and your registration or identification number and all family members with tribal affiliation:

_____

_____

Biological Mother's

Medical History

Please complete the following information as accurately as possible. We have wonderful adoptive families willing to accepted children having any medical condition or exposed to any drugs or alcohol. The information is utilized to determine the health of your baby.

HEALTH HISTORY OF BIOLOGICAL MOTHER

Place an "X" if the listed medical condition exists in your medical history or if any relatives or other family members have/had any of the conditions. If one of your relative's deaths was the result of a particular medical condition, note it on the comments section to the right of the condition and write the age at which they died.

<<IF UNSURE OF YOUR FAMILY'S MEDICAL CONDITIONS LEAVE BLANK>>

Medical Condition	You	Your mother	Your father	Your brother(s) or sister(s)	Your children	Indicate cause, treatment, medications, parts of body involved, age onset or other explanations. When more than one condition or family member is involved please
HIV/AIDS (medications prescribed)						
Cancer (be specific)						
Diabetes (insulin dependent Yes ☐ No ☐)						
Retardation: mental or physical (be specific)						
Down's Syndrome						
Diagnosed schizophrenia (medications prescribed)						
Diagnosed bi-polar (medications prescribed)						
Diagnosed Anxiety/Depression (medications prescribed)						
Feelings of Depression (non-diagnosed)						
Sickle cell anemia or trait						
Spina Bifida						
Congenital heart defect (be specific)						
Blindness (cause of blindness)						
Deafness (cause of deafness)						
Sudden Infant Death Syndrome (SIDS)						
Anorexia/Bulimia						
Epilepsy						
Problem pregnancies						
Other						
Other						
Other						

CONFIDENTIAL DRUG/ALCOHOL USAGE

Please be very specific as to any drugs or alcohol used during your pregnancy, including the number of times and the dates of usage. This information is very important for the prediction of your child's health. This information will be passed along to the adoptive family and to the child's pediatrician. Place an '**X**' in the applicable boxes and leave blank all other boxes.

DRUG & ALCOHOL USAGE	Used occasion-ally (1-5 times) during pregnancy	Used daily during pregnancy	Used weekly during pregnancy	Used monthly during pregnancy
Cigarettes				
Alcohol				
Marijuana				
Cocaine				
Methamphetamines				
Heroin				
Ecstasy				
Methadone				
LSD				
Stimulants (Caffeine included)				
Depressants				
Diet Pills				
Tranquilizers				
Anti-Convulsants				
Other (be specific)				
Other (be specific)				

Please be specific about any prescription drugs used or prescribed during your pregnancy:

Name: _____

Prescribed for: _____

Length used: _____

Please list any other medical issues that were not covered in the information above:

_____

_____

Please list any additional comments, concerns or questions you may have:

_____

_____

_____

I represent that the information contained in the Biological Mother's Social and Medical History is true and accurate. I acknowledge that the adoptive family and other parties will rely on this information in making a determination to proceed with the anticipated adoption. I hereby waive any claim of agency/client privilege and agree that the information contained on this form may be given to the adoptive parents, their agency, their attorney, and other state officials.

I further understand that I am entering into a program that places children for adoption and any false statements may be viewed as perjury and in violation of penal laws of my state and may subject me to criminal and/or civil penalties under the law.

Please sign and date on the line below.

_____ _____

Signature Date

You have just completed Stage I Social and Medical History forms. Please be aware that there will be an additional set of Social and Medical History forms for you to fill out and return to us; called Stage II. You will receive Stage II history forms upon receipt of Stage I.

Please complete and return to: American Adoptions (National Offices)
8676 W. 96th Street Suite 140, Overland Park, KS 66212
If you have questions please call 1-800-ADOPTION anytime.

Authorization for Release of Medical Information

I hereby request and authorize: American Adoptions

8676 West 96th Street Suite 140

Overland Park, KS 66212

To obtain from: Any hospital, physician, and/or medical provider

(address)

X	All medical information/reports	X	Immunization records
X	HIV test results	X	Prenatal medical records
X	X-ray reports	X	Alcohol and Drug screening
X	Physical examination reports	X	Medical Data for WIC Certification
X	Psychological Testing	X	Laboratory Reports

X Other (specify): any and all other medical reports or records

Except for the following, which may not be disclosed (if none, write 'none'): NONE

From the medical record of: _____
(print or type name, birth date and file number if applicable)

For the purpose of: Adoption

All information I hereby authorize to be obtained from this agency will be held in strictly confidential and cannot be released by the recipient without my express written consent. I understand that this authorization will remain in effect for 1 (one) year unless I specify an earlier date here: NONE

I understand that I may withdraw this consent at any time as long as the request is made in writing.

X _____ _____
Signature of Client or Legal Representative Date

Use this space only if client withdraws consent

_____ _____
Signature of Client Date of revocation

A COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL