BIRTHPARENT BACKGROUND INFORMATION

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CHILDREN AND FAMILY SERVICES-ADOPTIONS
SFN 930 (1-2023)

Clear Fields

Date

Information Concerning ☐ Birth Mother ☐ Birth Father	Name of Person Providing Information	Agency Name

Name of Child	Due Date of Baby or Date of Birth

Instructions for completion:

1. Print clearly - use a pen or type your answers.
2. Complete all items. If you don't know the answer to an item, write "unknown."
3. Identifying information (names, addresses, telephone numbers, locations and specific dates) will be kept confidential. No identifying information will be given to your birth child child or his/her adoptive parents unless you have given us written permission to do so. Nonidentifying information (background and health history) will be summarized and given to your child's adoptive parents prior to finalization of the adoption and upon written request of your birth child and/or adoptive parents after that time.

A. Identifying Information

Name (First, Middle, Last)	* Social Security Number	Date of Birth	Place of Birth

Address	City	State	Zip Code

Telephone Number	Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Living Together

Religion ☐ Active ☐ Inactive	Church Attended	Member ☐ Yes ☐ No

Race/Ethnic Group ☐ White ☐ Filipino ☐ Hispanic ☐ Black ☐ Asian or Pacific Islander ☐ American Indian or Alaskan Native ☐ Other

If American Indian, indicate the Tribe's name and location	Percent of Indian Blood, if known

Nationality (German, Norwegian, Irish, Mexican, etc.)

Name of Spouse	Date of Marriage	Place of Marriage

Date of Separation	Date of Divorce	Place of Divorce	Date of Death of Spouse

Address of Spouse	City	State	Zip Code

Spouse's Place of Employment

B. Physical Description/Personality

Height	Usual Weight	Bone Structure ☐ Small ☐ Medium ☐ Large	Eye Color

Natural Hair Color and Texture	Skin Color ☐ Fair ☐ Medium ☐ Dark	Dominant Hand ☐ Right ☐ Left

Describe any distinguishing physical features (i.e. shape of face, size of nose, significant birthmarks, freckles, acne, etc.).

Describe your personality (temperament, behavior, attitudes, moods, etc.).

Describe your present hobbies, interests, and pastime activities.

* In compliance with the Federal Privacy Act of 1974, disclosure of the social security number is voluntary and it is requested for identification purposes. Failure to disclose this information will not affect participation in this program.

C. Education

Name of Last School Attended	Year	Last Grade Completed	Average Grades	Do you have a GED? ☐ Yes ☐ No

Do you have future plans for schooling?

List any extra-curricular activities in which you participated during your school years.

List the subjects you were interested in during your school years.

Describe your educational/occupational goals.

D. Employment/Legal History

Current Occupation	Place of Employment	Length of Employment	Telephone Number

Address of Employer	City	State	Zip Code

Previous Occupations

Military Service ☐ Yes ☐ No If yes, List Branch of Service	Location Where You Served

Honorable Discharge
☐ Yes ☐ No If Yes, Date of Discharge

Have you ever had any legal problems?
☐ Yes ☐ No If Yes, Please Describe

E. Personal Health History

Describe your present general health.

Are you currently taking any medication?
☐ Yes ☐ No If Yes, Please List Name and Reason

List any childhood diseases you have had (chickenpox, mumps, measles, whooping cough, roseola, asthma, ear infections, heart murmur, scarlet fever, rheumatic fever, etc.).

List any major surgeries you have had (when and for what condition).

Blood Type and RH Factor (i.e. A+, AB-, O+, etc.)	Are you part of a multiple birth? ☐ Twin ☐ Triplet ☐ Other

For Birth Mother Only

Age Menstruation Started	Length of Period Each Month	List any problems with menstruation (i.e. PMS, severe cramps and or bleeding, etc.).

List any problems your mother or grandmother experienced during pregnancy or childbirth.

History of Miscarriage ☐ Yes ☐ No If Yes, Please List When	History of Abortion ☐ Yes ☐ No If Yes, Please List When

For Birth Mother Only - Information Related to this Pregnancy

Discovered You Were Pregnant	Prenatal Care Started	Predominant Feelings During this Pregnancy

Describe your general diet during this pregnancy	Describe any food craving you had during this pregnancy

Is the baby's father aware of this pregnancy?
☐ Yes ☐ No ☐ Not Sure If yes, describe how he feels about the pregnancy.

Using any type of birth control at the time of conception of this pregnancy	Receive any immunizations 3 months prior to or during this pregnancy
☐ Yes ☐ No If yes, please list what	☐ Yes ☐ No If yes, please list what type

Exposed to x-rays during this pregnancy (including dental x-rays)
☐ Yes ☐ No If yes, please list when and what body part was x-rayed

Ultrasound done during this pregnancy
☐ Yes ☐ No if yes, please list when and the results

Please indicate if you have experienced any of the following conditions during this pregnancy and list the treatment provided.	Treatment Provided
Morning Sickness ☐ Yes ☐ No	
Toxemia ☐ Yes ☐ No	
Diabetes (gestational) ☐ Yes ☐ No	
Placenta Previa ☐ Yes ☐ No	
Blood Pressure Change If yes, high or low ☐ Yes ☐ No	
Vaginal Bleeding ☐ Yes ☐ No	
Injuries (car accident, fall) If yes, when ☐ Yes ☐ No	
Infections or Illness If yes, explain ☐ Yes ☐ No	
German Measles ☐ Yes ☐ No	
Sexually Transmitted Disease If yes, indicate specific infection(s) ☐ Yes ☐ No ☐ Chlamydia ☐ Genital Herpes ☐ Genital Warts ☐ Gonorrhea ☐ Syphilis	

F. Background Information

Were you or any member of your family adopted?
☐ Yes ☐ No If yes, lease list who was adopted and the placing agency

Is the birth father/mother a genetic relative of yours?
☐ Yes ☐ No If yes, how is (s)he related?

	Your Birth Father	Your Birth Mother
First Name		
Date of Birth or Age		
Present Address		
If Deceased, Age at Death		
Cause of Death		
Present Health		
Height/Weight	Ht. Wt.	Ht. Wt.
Hair Color and Texture		
Eye Color		

	Your Birth Father	Your Birth Mother
Skin Color		
Hobbies and Talents		
Education Completed		
Occupation		
Previous Occupations		
Race/Ethnic Group (if Native American, note %)		
Nationality		
Religion		
Aware of Child's Adoption	☐ Yes ☐ No	☐ Yes ☐ No
Number of Brothers and Sisters		
If any of your aunts and uncles have died, note age and cause of death		

Your Father's Parents

	Father	Mother
First Name		
Age		
If Deceased, Age and Cause of Death		
Present Health		
Present Address		
Describe Physical Appearance		
Height/Weight	Ht. Wt.	Ht. Wt.
Outstanding Features		
Education Completed		
Current or Former Occupation		
Aware of Child's Adoption	☐ Yes ☐ No	☐ Yes ☐ No

Your Mother's Parents

	Father	Mother
First Name		
Age		
If Deceased, Age and Cause of Death		
Present Health		
Present Address		
Describe Physical Appearance		
Height/Weight	Ht. Wt.	Ht. Wt.
Outstanding Features		
Education Completed		
Current or Former Occupation		
Aware of Child's Adoption	☐ Yes ☐ No	☐ Yes ☐ No

Your Brothers and Sisters

First Name			
Sex			
Birth, Half, or Adoptive Sibling			
Date of Birth or Age			
Present Address			
If Deceased, Age and Cause of Death			
Height/Weight	Ht. Wt.	Ht. Wt.	Ht. Wt.
Hair Color and Texture			
Eye Color			
Skin Color			
Hobbies and Talents			
Last Grade Completed			
Presently in School	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Occupation			
Religion			
Present Health			
Aware of Child's Adoption	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Marital Status			
Name of Spouse			
Spouse's Place of Employment			
Spouse Aware of Child's Adoption	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Health and Ages of Their Children			

Your Brothers and Sisters - if more than three

First Name			
Sex			
Birth, Half, or Adoptive Sibling			
Date of Birth or Age			
Present Address			
If Deceased, Age and Cause of Death			
Height/Weight	Ht. Wt.	Ht. Wt.	Ht. Wt.
Hair Color and Texture			
Eye Color			
Skin Color			
Hobbies and Talents			
Last Grade Completed			
Presently in School	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Occupation			
Religion			
Present Health			

Your Brothers and Sisters - if more than three (continued)

Aware of Child's Adoption	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Marital Status			
Name of Spouse			
Spouse's Place of Employment			
Spouse Aware of Child's Adoption	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Health and Ages of Their Children			

Other Children Born to You

First Name			
Sex			
Date of Birth or Age			
Relationship to Child Being Adopted	☐ Full Sibling ☐ Half Sibling	☐ Full Sibling ☐ Half Sibling	☐ Full Sibling ☐ Half Sibling
Does this child live with you?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Was pregnancy and delivery normal? If not, list problems.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If Deceased, Age and Cause of Death			
Race/Ethnic Group			
Height/Weight	Ht. Wt.	Ht. Wt.	Ht. Wt.
Hair Color and Texture			
Eye Color			
Skin Color			
Presently in School	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Last Grade Completed			
General Health			
* If health problems exist, could they be linked genetically to the child being placed for adoption?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Aware of Child's Adoption	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

*** Please be sure to list any of these health problems on the medical history forms that follow.**

Other Children Born to You - if more than three

First Name			
Sex			
Date of Birth or Age			
Relationship to Child Being Adopted	☐ Full Sibling ☐ Half Sibling	☐ Full Sibling ☐ Half Sibling	☐ Full Sibling ☐ Half Sibling
Does this child live with you?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Was pregnancy and delivery normal? If not, list problems.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If Deceased, Age and Cause of Death			
Race/Ethnic Group			
Height/Weight	Ht. Wt.	Ht. Wt.	Ht. Wt.
Hair Color and Texture			
Eye Color			

Other Children Born to You - if more than three (continued)

Skin Color			
Presently in School	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Last Grade Completed			
General Health			
* If health problems exist, could they be linked genetically to the child being placed for adoption?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Aware of Child's Adoption	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

*** Please be sure to list any of these health problems on the medical history forms that follow.**

G. Medical History for You, Your Parents, and Other Relatives

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

Medical Condition	No/ For All	Not Known	Yes/ Self	Yes/ Relative (specify relationship)	Comments
1. Down's Syndrome					
2. Hydrocephalus					
3. Microcephaly & Macrocephaly					
4. Congenital Heart Defect					
5. Open Spine, Spina Bifida					
6. Spinal Curvature, Scoliosis					
7. Facial Abnormalities (cleft lip/palate)					
8. Club Foot					
9. Feet Abnormalities (extra, missing, webbed toes)					
10. Hand Abnormalities (extra, missing, webbed fingers)					
11. Muscular Dystrophy					
12. Sickle Cell Anemia					
13. Tay-Sachs Disease					
14. Eczema or other skin problems					
15. Hay Fever					
16. Allergies (foods, dust, pollens, pets, etc.)					
17. Drug Allergies					
18. Blindness, Glaucoma, Cataracts, etc.					
19. Corrective Glasses or Contacts					
a) Farsighted					
b) Nearsighted					
c) Astigmatism (inability to focus)					
d) Strabismus (cross-eye)					
20. Color Blindness					

Medical Condition	No/ For All	Not Known	Yes/ Self	Yes/ Relative (specify relationship)	Comments
21. Hearing Difficulties/ Deafness					
22. Speech Problems (stutter, stammering, lisp)					
23. Corrective Orthodontia (braces, overbite/ underbite, irregularity)					
24. Learning Disability (Dyslexia, other)					
25. Retardation - Mental or Physical					
26. Bleeding Problems/ Hemophilia					
27. Anemia (Sickle Cell or other)					
28. Hypertension/ High Blood Pressure					
29. Aneurysm					
30. Lupus					
31. Stroke					
32. Heart Attack (coronary, heart failure, angina)					
33. Alzheimer's/Sensitivity					
34. Arthritis					
35. Kidney Disease					
36. Bladder Problems					
37. Headaches/Migraines					
38. Diabetes					
39. Hypoglycemia					
40. Thyroid Disorder (low or overactive)					
41. Other Hormone/ Growth Disorder (too tall, too short, PKU)					
42. Dwarfism					
43. Asthma					
44. Emphysema or Other Breathing Problems					
45. Tuberculosis					
46. Diagnosed Schizophrenia					
47. Diagnosed Bi-polar Disorder					
48. Other Mental Illness (describe)					
49. Diagnosed Depression/ Depressive Personality					
50. Counseling/Therapy					
51. Alcoholism/Heavy Drinking					
52. Drug Use					
53. Attention Deficit Disorder/ Hyperactivity, ADHD					

Medical Condition	No/ For All	Not Known	Yes/ Self	Yes/Relative (specify relationship)	Comments
54. Eating Disorders					
55. Weight Problems (heavy or slim)					
56. Cancer					
57. Cystic Fibrosis					
58. Lou Gehrig's Disease					
59. Hodgkin's Disease					
60. Tumors of Other Kinds					
61. Multiple Sclerosis					
62. Huntington Chorea					
63. Cerebral Palsy					
64. Myasthenia Gravis (or other neuro-muscular disorder)					
65. Seizures or convulsion					
66. Epilepsy					
67. Infertility					
68. Sexually Transmitted Diseases					
69. HIV/Testing (positive or negative)					
70. Miscarriages (number and cause, if known)					
71. Stillbirths (number and cause, if known)					
72. Other Problem Pregnancies					
73. Undescended Testicles					
74. Patches of Hair Different Color					
75. Patches of Skin of Different Color					
76. Birthmarks (note unusual configuration, size, and number)					
77. Unusual Scarring					
78. Baldness					

Other Medical or Health Problems

H. Personal Use of Substances

Have you ever been in chemical dependency treatment?

☐ No ☐ Yes - Please list when and where

Have you ever been an IV drug user?

☐ No ☐ Yes - Please list when and any treatment

Please indicate whether you have used the listed substance in the past (check Prior History of Use) and/or in This Pregnancy. Specify the particular name of the substance, if requested. **Note under the appropriate trimester how much of the substance was used and how often.** Please refer to the example.

	Prior History of Use	This Pregnancy	1st Trimester (1-3 months)	2nd Trimester (4-6 months)	3rd Trimester (7-9 months)
Example: Alcohol	*Yes*	*Yes*	*2 beers on 3 occasions*	*None*	*None*
1. Prescription Medication Name:					
2. Non-prescription Medications (including aspirin, nose drops, diuretics, etc.) Name:					
3. Alcohol (if you drank during this pregnancy, please list by name - i.e. beer, wine, liquor, etc.) Name:					
4. Amphetamines/ Methamphetamine (pep pill, uppers, crank, ice, speed)					
5. Barbiturates (downers)					
6. Crack/Cocaine					
7. Heroin					
8. LSD (acid)					
9. Angel Dust (PCP)					
10. Marijuana					
11. Inhalants					
12. Cigarettes or other tobacco products					

I. Assurances/Signatures

At this time, I feel I would like to be contacted by my child when he/she reaches adulthood ☐ Yes ☐ No

If you desire to be contacted, please continue to send the agency your current name and address. Include pictures if desired. If you should become aware of any new health, medical, or hereditary information that could affect your child, please contact the agency.

I understand the non-identifying information I have given will be shared with my child's adoptive family.

Indicate below your reasons for making a placement plan for your child. Include your hopes and dreams for this child and any biographical statements you wish, information regarding your relationship with your child's other parent, or anything else you might want to convey about your family history. This "gift" of information will be welcomed by your child. *** Please attach a picture of yourself or other family members if possible. (Attach additional pages if needed.)**

Birth Parent Completing Form		Date
Parent/Guardian Providing Information		Date
Person Assisting with Completion	Relationship	Date