AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION
Pursuant to HIPAA
(Mother's Information)

TO: All Hospitals, Doctors, and other Medical Providers
Dates of Treatment: Date of first Treatment for the Pregnancy to 60 days after the Discharge from all Hospitals for the Birth of Child(ren) due on or about _____, 20_____
Patient Name: _____
Date of Birth: _____ **Social Security No.: xxx-xx-_____ (Last 4 digits)**
Patient's Address: _____

I, the undersigned, hereby authorize the above-named health care provider, all physicians, hospitals, and other health care professionals who provide care to, or consult in the care of, me (collectively referred to as "Health Care Providers") to disclose to KIRSH & KIRSH, P.C., 2930 East 96th Street, Indianapolis, Indiana 46240, and to "Recipients" (as defined below) my health information, including, without limitation, the following: all medical, general, psychological, psychiatric, membership, billing, and/or health information pertaining to me which is now or in the future may be in the possession or under the control of Health Care Providers including specifically, and without limitation, the results of any and/or all autoimmune deficiency (HIV/AIDS) testing, drug, alcohol, sexually transmitted disease, Hepatitis A, B, and C, and Herpes tests. I understand that this information may include information relating to sexually transmitted diseases, Human immunodeficiency Virus (HIV infection, Acquired Immune Deficiency Syndrome or AIDS Related Complex), and other communicable diseases. It may also include information about behavioral or mental health services, and referral or treatment for alcohol and drug abuse (as permitted by 42 CRF Part 2). KIRSH & KIRSH, P.C., and Recipients may further disclose this information to any or all of the following persons and organizations, who are defined as "Recipients":

- Attorney(s) for adoptive or birth parent(s)
- Agency for adoptive parent(s)
- Interstate Compact on the Placement of Children
- County or State Public Adoption Agencies
- Native American Nations or Tribes/Alaska Native Villages
- Physicians and other health care professionals consulted by any of these persons and organizations
- Other persons or organizations deemed necessary by KIRSH & KIRSH, P.C., or Recipients to facilitate the adoption of my child
- Adoptive parent(s)
- Court in connection with adoption

This disclosure and use is for the following purposes: Adoption, custody, guardianship, parental rights matters, Indian Child Welfare Act inquiries, and ICWA and ICPC clearances.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department of the Health Care Providers. Unless otherwise revoked, this authorization will expire eighteen months from the signature date. I understand that authorizing the disclosure of this health information is voluntary. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or eligibility for benefits. This document also authorizes any Native American tribe, Indian tribe or Alaska Native Village to release information about the membership status or eligibility for membership of myself or my child born or to be born.

By signing this Authorization, I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal privacy rules. I further understand I may request a copy of this signed authorization. A photocopy of this authorization shall be deemed as valid as the original for all purposes.

_____ _____
Witness Signature of Parent/Patient

Date: _____ _____
Signature of Other Authorized Person/Relationship

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION
Pursuant to HIPAA
(Infant's Information)

TO: All Hospitals, Doctors, and other Medical Providers

Patient Name: Infant _____
Dates of Treatment: From Birth to Discharge from all Hospitals following Birth
Date of Birth (or Estimated Date of Birth): _____, 20___

I, the undersigned, on behalf of my child hereby authorize the above-named health care provider, all physicians, hospitals, and other health care professionals who provide care to, or consult in the care of, my child (collectively referred to as "Health Care Providers") to disclose to KIRSH & KIRSH, P.C., 2930 East 96th Street, Indianapolis, Indiana 46240, and to "Recipients" (as defined below) my child's health information, including, without limitation, the following: all medical, general, psychological, psychiatric, membership, billing, and/or health information pertaining to child which is now or in the future may be in the possession or under the control of Health Care Providers including specifically, and without limitation, the results of any and/or all autoimmune deficiency (HIV/AIDS) testing, drug, alcohol, sexually transmitted disease, Hepatitis A, B, and C, and Herpes tests. I understand that this information may include information relating to sexually transmitted diseases, Human immunodeficiency Virus (HIV infection, Acquired Immune Deficiency Syndrome or AIDS Related Complex), and other communicable diseases. It may also include information about behavioral or mental health services, and referral or treatment for alcohol and drug abuse (as permitted by 42 CRF Part 2). KIRSH & KIRSH, P.C., and Recipients may further disclose this information to any or all of the following persons and organizations, who are defined as "Recipients":

- Attorney(s) for adoptive or birth parent(s)
- Agency for adoptive parent(s)
- Interstate Compact on the Placement of Children
- County or State Public Adoption Agencies
- Native American Nations or Tribes/Alaska Native Villages
- Physicians and other health care professionals consulted by any of these persons and organizations
- Other persons or organizations deemed necessary by KIRSH & KIRSH, P.C., or Recipients to facilitate the adoption of my child
- Adoptive parent(s)
- Court in connection with adoption

This disclosure and use is for the following purposes: Adoption, custody, guardianship, parental rights matters, Indian Child Welfare Act inquiries, and ICWA and ICPC clearances.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department of the Health Care Providers. Unless otherwise revoked, this authorization will expire eighteen months from the signature date. I understand that authorizing the disclosure of this health information is voluntary. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or eligibility for benefits. This document also authorizes any Native American tribe, Indian tribe or Alaska Native Village to release information about the membership status or eligibility for membership of myself or my child born or to be born.

By signing this Authorization, I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal privacy rules. I further understand I may request a copy of this signed authorization. A photocopy of this authorization shall be deemed as valid as the original for all purposes.

_____ _____
Witness Signature of Parent/Patient

Date: _____ _____
Signature of Other Authorized Person/Relationship

AUTHORIZED REPRESENTATIVE FOR HEALTH COVERAGE

State Form 55366 (R2 / 12-14) / DFR 2123HC

Section 1

If you want someone to act on your behalf in applying for benefits and/or act for you on an ongoing basis, this form must be completed. Be sure to select the function(s) that the representative is being authorized to do. You can select more than one representative and choose the same or different functions. The representative may be an individual or an organization. Complete ONE form per authorized representative. Both you and your representative must sign and date this form.

Section 2

Name of Representative (*Please print clearly*)

Jill Freeman

Check association with applicant/recipient. Please select ONE *(1)*.

☐	Attorney	☐	Eligibility Assistance Company	☐	Friend	☐	Family
☐	Institution of Residence	☐	Waiver Case Manager	☒	Other (*Specify*): Authorized Representative		

Mailing Address (*number and street, city, state, and ZIP code*)

2930 E. 96th Street Indianapolis, Indiana 46240

		SELECT THE FUNCTION(S) THE AUTHORIZED REPRESENTATIVE WILL DO:
FUNCTION	**FUNCTION DESCRIPTION**	**HEALTH COVERAGE**
APPLY	• Sign application and be interviewed. • Provide all required proof of information necessary to determine eligibility for benefits. • Receive the Notice of the application decision. • Speak on applicant's behalf at a hearing if the application decision is appealed.	**Apply** ☒
ONGOING	• Report changes. • Attend periodic redeterminations. • Receive the appointment notices and any redetermination mail-in forms. **NOTE:** Do not check this function if the representative will not continue to act on recipient's behalf after the application decision is made.	**Ongoing** ☒

In agreeing to be the authorized representative, I understand that I am expected to be knowledgeable of the applicant's/recipient's circumstances and that this authorization can be revoked by the applicant/recipient at any time. I agree to maintain or be legally bound to maintain the confidentiality of any information regarding the applicant/recipient provided by the Division of Family Resources.

Signature	Date (*mm/dd/yyyy*)	Telephone ((###) ###-####)
Jill Freeman	/ /201	317-575-5555

Section 3

I authorize this representative to act for me in taking care of the functions and program eligibility process which I have checked above. (If applicant/recipient is medically incapable to sign authorization, provide medical documentation.) I understand that I am responsible for the information anyone acting as my authorized representative gives, including any information that may be incorrect. I also understand that if at any time I wish to stop the person(s) I chose from being my authorized representative, it is my responsibility to contact the Division of Family Resources.

Applicant/Recipient Name	Applicant/Recipient Signature	Date (*mm/dd/yyyy*)
	X	/ /201

Case Number (*Optional*)	Applicant/Recipient Date of Birth (*mm/dd/yyyy*)	Applicant/Reciipient Social Security Number
		XXX-XX-

and for the baby X_____

Birth Mother's Background Form

Please read before completing this background form. This form asks many, many questions. If you don't know the information or are uncomfortable completing any section, please skip it. Having said that, please read the following letter, written by one of our clients and do the best you can. Thank you!

Dear Birth Parent:

Attached is a background from which you have been asked to complete in regards to a possible adoption of your child. Before you begin, I would like to share with you my perspective as an adoptive parent of a wonderful son, whom my husband and I adopted when he was just a few days old. He is now 6.

While *not* every child who is adopted has problems, our son, from an early age exhibited some types of behavior which concerned us. According to the medical history given to us by his birth parents, there were no indications of any hereditary problems.

From an early age, I noticed developmental delays. While he has really good coordination and is extremely athletic, he was much slower developing in most other areas. He was very hyperactive and impulsive to the point that he did some very dangerous things. He knew right from wrong, but he could not think quickly enough of the consequences of his actions. He also had trouble controlling his temper and became frustrated very easily. We took him to a child psychologist who tested him in many areas of development. The diagnosis she gave us is ADHD or Attention Deficit Hyperactive Disorder. He is doing better thanks to medication and we are continuing to educate ourselves about how we can help him achieve his full potential.

Unfortunately, because of an incomplete medical history, we are still not sure we have a correct diagnosis for our son. Had the medical history we received from the birth parents been more detailed, we could have saved our son considerable testing, stress, and frustration. Furthermore, we might have been able to provide more appropriate treatment, at an earlier age.

Please understand that we love our son and *would have adopted him in spite of what might have been disclosed in his medical histories*. As parents, it was very hard for us to see our son struggling and not be able to help him.

This brings me to my reason for writing this letter – specifically, I want to encourage birth parents to make every effort to provide detailed and accurate information. That may

mean talking to relatives and asking some hard questions, but ultimately, it will be your child who benefits from the information.

Additionally, I realize that in some situations, you might not know all of your medical history before the adoption becomes final or you may discover additional medical information at a later time. In either case, I urge you to contact Steve or Joel Kirsh with additional information as it becomes available. In fact, our son's birth mother recently discovered some medical conditions in her family of which she was not aware previously and contacted Kirsh & Kirsh, who, in turn, immediately passed the information on to us. We were happy to hear from her and are thankful for this new information that should help us in our efforts to provide the best possible care for our son.

I hope that in sharing my experiences as an adoptive mother, you will not only realize what a difference it could make as your child is growing up, but also how much we, as adoptive parents, appreciate it.

On behalf of all adoptive parents, we thank you for trying to provide us with the background information that we need in order to be the best possible parents. Thank you, especially, for giving us the opportunity to realize our dream of being parents.

A Loving Adoptive Mom

This form is designed to provide birth mother's health history, genetic and social background information which will be helpful to adoptive parents in parenting the child. It is important that they have this information so that it can become a part of their family history. Perhaps it will be most important when the child begins to ask questions. Answers will then be readily available about interests, talents, appearance, medical and genetic history. For these reasons, please be as thorough as possible in answering all of the questions.

The following information is true and complete to the best of my knowledge and belief.

Signed: _____

Date Form Completed: _____By Whom: _____

Birth Mother's Social & Family History

Print Name*:* _____

Birth date _____

Birth place _____

Social Security # _____

Driver's License: State_____ Number_____

Current Address: _____

_____

Street City State Zip

How Long at This Address: _____

Permanent Address (If different)

_____

Street City State Zip

Where did you grow up (city/town & state)? _____

BIRTH MOTHER'S RACE/ETHNICITY

Were you or any member of your immediate family adopted? Yes ☐ No ☐
If yes, specify which family member(s) _____

Race (check all that apply)

☐ Caucasian/White ☐ African-American ☐ American Indian* ☐ Asian

☐ Native Hawaiian or other Pacific Islander ☐ Alaskan Native ☐ Hispanic ☐ Filipino

☐ Other_____

**** If you check this box, please complete the Native American-Indian Addendum attached to this form.***

Nationality/Ethnic Background (e.g., Irish, French, Mexican, Puerto Rican, Italian, Greek, Nigerian, Russian, Chinese)

_____

Are you a citizen of the United States? Yes ☐ No ☐

Are you a permanent resident (with a green card) of the United States? Yes ☐ No ☐

EMPLOYMENT INFORMATION

Are you currently employed? Yes ☐ No ☐
If yes, type of job _____
Name & address of employer_____
Work Phone (with area code) _____

Can we contact you at work? Yes ☐ No ☐

Do you like your job? Yes ☐ No ☐
What is the best job you ever had and/or your ideal job and why? _____

_____

_____

Is your employer aware of your plan for adoption? Yes ☐ No ☐

Previous Employment (type of job and dates of employment):_____

_____

_____

Career Goals: _____

EDUCATION

Number of years attended:

Grade School _____ Completed/graduated? Yes ☐ No ☐

Were you ever "held back" in school? Yes ☐ No ☐

Were you ever "skipped ahead" in school? Yes ☐ No ☐

High School _____ Completed/graduated? Yes ☐ No ☐

Grades: Superior ☐ High ☐ Average ☐ Poor ☐ Could have done better ☐

How would you describe your high school experience? _____

_____

College _____ Major/Degree_____ Completed/graduated? Yes ☐ No ☐

How would you describe your college experience? _____

_____

Vocational or other Training:

_____

Did you like school? Yes ☐ No ☐

Did you have a lot of friends in school? Yes ☐ No ☐

Did you make friends easily? Yes ☐ No ☐

In which of the following subjects did you make good grades or excel (check all that apply)?

Reading ☐ Math ☐ Science☐ History☐ Spelling☐ English☐ Foreign language☐

Social Studies☐ Art ☐ Drama ☐ Sports☐ Other☐: _____

In which of the following subjects did you make poor grades or struggle (check all that apply)?

Reading ☐ Math ☐ Science☐ History☐ Spelling☐ English☐ Foreign language☐

Social Studies☐ Art ☐ Drama ☐ Sports☐ Other☐: _____

If you did not graduate from high school or get a GED, why?

_____

Academic or Educational Achievements/Awards _____

Educational Goals: _____

MILITARY HISTORY

Did you serve in the Armed Forces? Yes ___ No ___ If so, which Branch? _____
Dates of Service: _____ Highest rank achieved: _____

Discharge? Honorable ☐ Dishonorable ☐
If Dishonorable, please explain: _____

RELIGION

Do you practice any religion or attend any religious services? Yes ☐ No ☐
If yes, what is your religious denomination? _____

INTERESTS/TALENTS/HOBBIES

Please give a brief description of what your interests are now. Describe your hobbies, special talents or abilities. What are your personal goals at this time?

_____

_____

_____

Do other members of your family (grandparents, parents, children) have similar hobbies, special talents or abilities? Please describe

_____

_____

_____

Do you speak or write any languages other than English?
If so, what other languages? _____

Were you involved in any school activities or sports? Yes ☐ No ☐
If so, describe _____

What are your favorite foods and drinks? _____

What is your favorite place? _____
What is your favorite TV show? _____

What is your favorite pet? _____

What is your favorite color? _____

What is your favorite kind of flower? _____

Who is your favorite famous person? _____
Why? _____

What is your favorite style/type of clothes? _____

What is your favorite holiday? _____

What type of music do you prefer?_____

What is your favorite season? Winter ☐ Spring ☐ Summer ☐ Fall ☐

How would you describe your personality as a child, your usual behavior, attitudes, moods, favorite activities, types of people you enjoyed being with, etc.

_____

_____

_____

How do you think your closest friends would describe you?

_____

_____

What would you like to change about yourself?

_____

_____

What bothers you most about others?

_____

_____

What would you like this child to know about you and your family?

_____

_____

RELATIONSHIP BETWEEN BIRTH PARENTS

Please give a brief description of how you met, the quality of your relationship, interests shared, involvement during pregnancy, whether he knows you are pregnant, his reaction when he found out, any financial assistance or emotion support he provided to you upon learning of the pregnancy, and future relationship.

_____

_____

Birth Mother's Other Children
Siblings of Child to be Adopted
If more than 4 children use additional paper

	Sibling #1	**Sibling #2**	**Sibling #3**	**Sibling #4**
Name				
Sex	Male ☐ Female ☐	Male ☐ Female ☐	Male ☐ Female ☐	Male ☐ Female ☐
Full or half sibling to this child	Full ☐ Half ☐	Full ☐ Half ☐	Full ☐ Half ☐	Full ☐ Half ☐
Does this child live with you?	Yes ☐ No☐	Yes ☐ No☐	Yes ☐ No☐	Yes ☐ No☐
Age or Year of Birth				
General health	Excellent ☐ Good ☐ Fair ☐ Poor ☐	Excellent ☐ Good ☐ Fair ☐ Poor ☐	Excellent ☐ Good ☐ Fair ☐ Poor ☐	Excellent ☐ Good ☐ Fair ☐ Poor ☐
Major surgery? (describe)				
Health problems? (describe)				
If deceased, age at & cause of death				
Race				
Education				
Hobbies, Talents, Interests				

	Sibling #1	**Sibling #2**	**Sibling #3**	**Sibling #4**
Occupation				
Height				
Weight				
Hair Color				
Eye Color				
Complexion (skin tone)	Fair ☐ Medium ☐ Dark ☐	Fair ☐ Medium ☐ Dark ☐	Fair ☐ Medium ☐ Dark ☐	Fair ☐ Medium ☐ Dark ☐
Was/Is this child aware of your pregnancy?	Yes ☐ No☐	Yes ☐ No☐	Yes ☐ No☐	Yes ☐ No☐
Personality				

Is there any other information you would like to share with adoptive parent(s) about your other children? Yes ☐ No ☐ If yes, specify _____

_____

_____

Birth Mother's Extended Family

If more than 2 sisters or brothers use additional paper

	Your Mother	**Your Father**	**Your Sister or Brother #1**	**Your Sister or Brother #2**
Name				
Age or Year of Birth				
If deceased, age at & cause of death				
Race				
Education				
Hobbies, Talents, Interests				
Occupation				
Height				
Weight				
Hair Color				
Eye Color				
Complexion (skin tone)	Fair ☐ Medium ☐ Dark ☐	Fair ☐ Medium ☐ Dark ☐	Fair ☐ Medium ☐ Dark ☐	Fair ☐ Medium ☐ Dark ☐
Religion				
Personality				

Please give a brief description of your childhood home, relationship with your parents and siblings and family life

_____

_____

_____

If you have any siblings, are you a twin or triplet? Yes ☐ No ☐

If yes, describe and indicate whether you are Identical ☐ Fraternal ☐

Birth Mother's Grandparents

	Your Mother's Mother	Your Mother's Father	Your Father's Mother	Your Father's Father
Name				
Age or Year of Birth				
If deceased, age at and cause of death				
Race				
Education				
Hobbies, Talents, Interests				
Occupation				
Height				
Weight				
Hair Color				
Eye Color				
Complexion (skin tone)	Fair ☐ Medium ☐ Dark ☐	Fair ☐ Medium ☐ Dark ☐	Fair ☐ Medium ☐ Dark ☐	Fair ☐ Medium ☐ Dark ☐
Religion				
Personality				

Please give a brief description of your relationship with your grandparents and what their home was like.

_____

_____

_____

Do you have any family members who were very special in your life? Yes ☐ No ☐

If yes, why? _____

_____

Birth Mother's Medical History

BIRTH MOTHER'S PHYSICAL CHARACTERISTICS & PREFERENCES

Eye Color: _____

Height: _____ Weight (before pregnancy): _____ Body Build: _____

Complexion: ☐ Fair ☐ Olive ☐ Tan ☐ Dark ☐ Other _____

Is your skin sensitive? Yes ☐ No ☐

Hair Color: ☐ Blonde ☐ Brunette ☐ Red ☐ Other: _____

Hair Texture ☐ Straight ☐ Naturally Curly ☐ Wavy ☐ Fine ☐ Thick

Hair Style preference ☐ Long ☐ Short

Did you ever wear braces for your teeth, or told that you should? Yes ☐ No ☐

Do you wear glasses or contact lenses? Yes ☐ No ☐

If yes, what age did you start wearing them? _____

Are you right-handed or left-handed? Right ☐ Left ☐

At what age did you start menstruation? _____

Did you have any problems with it, such as cramping or headaches? Yes ☐ No ☐

If yes, describe _____

Blood Type: _____ Rh factor: Positive ☐ Negative ☐

HEALTH HISTORY OF BIRTH 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. ***Use additional pages if needed.***

Medical Condition	None	You	Your mother or father	Your grand-parents	Your brother(s) or sister(s)	Your children	Indicate cause, treatment, medications, and parts of body involved, age onset or other explanations. When more than one condition or family member is involved please indicate and use other pages
HIV/AIDS (medications prescribed)							
Breast Cancer (be specific, age at onset)							
Cervical Cancer (be specific, age at onset)							
Uterine Cancer (be specific, age at onset)							
Ovarian Cancer (be specific, age at onset)							
Bone Cancer (be specific, age at onset)							
Prostrate Cancer (be specific, age at onset)							
Lung Cancer (be specific, age at onset)							
Melanoma/ Skin Cancer (be specific, age at onset)							
Stomach Cancer (be specific, age at onset)							
Liver Cancer (be specific, age at onset)							
Pancreatic Cancer (be specific, age at onset)							
Brian tumor							
Other cancer (specify)							
Diabetes (insulin dependent? Adult or juvenile?)							

Medical Condition	None	You	Your mother or father	Your grand-parents	Your brother(s) or sister(s)	Your children	Indicate cause, treatment, medications, and parts of body involved, age onset or other explanations. When more than one condition or family member is involved please indicate and use other pages
Retardation: mental or physical (be specific)							
Down's Syndrome							
Turner's Syndrome							
Hydrocephalus (water on the brain)							
Microencephalus							
Other developmental disorders (be specific)							
Diagnosed schizophrenia							
Obsessive Compulsive Disorder							
Serious depression							
Repeated infections							
Lymphoma							
Neuro Tube Defect							
Fetal alcohol syndrome or effect							
Trisomy							
Ambiguous genitalia							
Osteoporosis							
Colitis							
Malnutrition							
Apnea Monitor							
Bed wetting							
Gynecological problems (specify)							
Wilson's Disease							
Gout							
Diagnosed manic depressive (medications prescribed)							
Sickle cell anemia or trait							
Cystic fibrosis							
Leukemia							
Club foot or any orthopedic problem							

Medical Condition	None	You	Your mother or father	Your grand-parents	Your brother(s) or sister(s)	Your children	Indicate cause, treatment, medications, and parts of body involved, age onset or other explanations. When more than one condition or family member is involved please indicate and use other pages
Harelip (Cleft lip) or Cleft palate							
Cerebral Palsy							
Muscular dystrophy							
Dwarfism							
Spina Bifida							
Congenital heart defect (be specific)							
Tuberculosis							
Thyroid Disorder							
Hay fever							
Food allergy(s)							
Drug allergy(s) (name of drug(s))							
Other allergy(s) (be specific)							
Farsighted							
Nearsighted							
Astigmatism (inability to focus)							
Different color eyes							
Night blindness or color blindness							
Glaucoma							
Detached retina Blindness (cause of blindness)							
Cataracts or other visual problems (be specific)							
Strabismus (cross-eyed)							
Sinus or nasal problems							
Ear infections							
Deafness (cause of deafness)							
Other ear problems							

Medical Condition	None	You	Your mother or father	Your grand-parents	Your brother(s) or sister(s)	Your children	Indicate cause, treatment, medications, and parts of body involved, age onset or other explanations. When more than one condition or family member is involved please indicate and use other pages
Teeth problems (specify)							
Gum disease							
Hypertension (high blood pressure)							
Heart murmurs							
Mitral valve prolapse							
Heart attack (coronary)							
Hemophilia (free bleeder)							
Stroke							
Congestive Heart Defect							
Anemia							
Cooley's anemia (Thalassemia)							
Heart Surgery (date of surgery)							
Blood disorder (specify)							
Alzheimer's Disease							
Eczema, acne or other skin condition							
Hives							
Atherosclerosis							
Mononucleosis							
Hepatitis (specify type)							
Jaundice or yellow skin							
Cirrhosis							
Other liver problems							
Scoliosis (curvature of spine) or hunchback							
Back problems (pinched nerve, slipped disc)							
Arthritis							
Lupus							
Rheumatic Fever							

Medical Condition	None	You	Your mother or father	Your grand-parents	Your brother(s) or sister(s)	Your children	Indicate cause, treatment, specific medications, and parts of body involved, age onset or other explanations. When more than one condition or family member is involved please indicate and use other pages
Atrial Fibrillation							
Irregular/abnormal heart beat							
Any other heart or circulatory problems (be specific)							
Asthma (medications prescribed)							
Chronic Bronchitis							
Sudden Infant Death Syndrome (SIDS)							
Pneumonia							
Reactive airway disease							
Angina							
Other respiratory disorders							
Ulcers (be specific)							
Gall bladder problem							
High Cholesterol							
Obesity							
Anorexia/Bulimia							
Suicide or attempted suicide							
Other Digestive Disorders (be specific)							
Bladder Problems							
Kidney failure/transplant or problems							
Kidney stones							
Speech problems							
Learning disability (specify diagnosis)							
Dyslexia							
Autism							
Hyperactivity ADHD/ADD							
							Indicate cause, treatment,

Medical Condition	None	You	Your mother or father	Your grand-parents	Your brother(s) or sister(s)	Your children	medications, and parts of body involved, age onset or other explanations. When more than one condition or family member is involved please indicate and use other pages
Eczema or other skin conditions							
Alcoholism or heavy drinking							
Drug usage (list specific drugs)							
Other mental or behavioral disorders (be specific)							
Multiple sclerosis							
Lou Gehrig's disease							
Seizures or convulsions (medications prescribed)							
Huntington's disease							
Parkinson's Disease							
Epilepsy							
Tourette syndrome							
Crohn's Disease							
Lyme Disease							
Migraine headaches							
Other nervous system disorders (be specific)							
Arthritis							
Hodgkin's disease							
Cysts, lumps, or growths							
Endometriosis							
Menstrual problems							
Problem pregnancies							
Emphysema							
Chromosome abnormality							
Tay-Sachs Disease							

Medical Condition	None	You	Your mother or father	Your grand-parents	Your brother(s) or sister(s)	Your children	Indicate cause, treatment, medications, and parts of body involved, age onset or other explanations. When more than one condition or family member is involved please indicate and use other pages
Birthmarks (unusual size or shape)							
Pyloric stenosis (projectile vomiting)							
Neurofibromatosis							

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:

Date(s) and reasons for treatment (including diagnosis): _____

_____

_____

Name and location of therapist and/or agency who provided treatment:

_____

_____

_____

Indicate medications prescribed during treatment

_____

_____

Reason for discontinuance, if no longer in treatment

_____

_____

Please list any other medical issues or information about you or your family that were not covered in the information above:

_____

_____

Would you be willing to be contacted in the future if a health problem arises for the child which requires either additional health history, transfusion or an organ transplant?

Yes ☐ No ☐ Comments_____

_____

_____

Birth Mother's Pregnancy History
Medical

MOTHER'S BIRTH HISTORY

Your weight at birth _____

Your length at birth _____

Were ***you*** born Full term ☐ Premature ☐ Postmature ☐

Were ***you*** delivered by Vaginal (normal) delivery ☐ Caesarian (C-Section) ☐

Any complications with ***your*** delivery or birth? Yes ☐ No ☐

If yes, please describe: _____

PREGNANCY HISTORY

At what age did you get your first menstrual period? _____

Is this your first pregnancy? Yes ☐ No ☐

If no, how many prior pregnancies? _____

Please indicate what occurred with prior pregnancies: (indicate #)

Abortion: ____ Miscarriage: ____

Birth: ____ Vaginal delivery: ____ C-Section: ____

Were there any problems or complications with prior pregnancies or births? Yes ☐ No ☐

If yes, please describe: _____

_____

Were any of your other children/pregnancies premature? Yes ☐ No ☐

Were any of your other children multiple births (twins or triplets)? Yes ☐ No ☐

PREGNANCY INFORMATION

What is your due date? _____

What was your age when you became pregnant? _____

What was the date of your last period? _____

How far along was your pregnancy before you realized that you were pregnant? _____

Has your pregnancy been confirmed by testing (other than a home test)? Yes ☐ No ☐
If yes, when and where: _____

Have you ever used birth control? Yes ☐ No ☐
If yes, what type and duration of use: _____

Were you using birth control when you became pregnant? Yes ☐ No ☐
If yes, please indicate what type: _____

Did you have any food cravings during this pregnancy? Yes ☐ No ☐
If yes, please describe: _____

Within the 30 day period before or after conceiving your baby with the Birth Father, did you have intercourse with anyone else? Yes ☐ No ☐

Are you biologically related to the father of this child? Yes ☐ No ☐
If yes, how? _____

What is the race/ethnicity of your baby? (Check **all** that apply)

☐ Caucasian/White ☐ African-American ☐ Hispanic or Latino

☐ American Indian* ☐ Asian ☐ Native Hawaiian or other Pacific Islander

☐ Alaskan Native ☐ Unable to Determine ☐ Other_____

If Native American (American Indian) or Alaskan Native, specify name of tribe, tribal registration number, and degree of Indian blood if known _____

Have you been involved in any accidents during this pregnancy? Yes ☐ No ☐
If yes, please describe in detail: _____

_____

Has anyone hit you, knocked you down or shoved you during this pregnancy? Yes ☐ No ☐
If yes, please describe in detail, including whether you called the police or got medical attention: _____

_____

To your knowledge, were you exposed to lead or mercury during this pregnancy?

Yes ☐ No ☐ If yes, please describe: _____

Have you had excessive bleeding during this pregnancy? Yes ☐ No ☐
If yes, please explain: _____

Have you had any kidney or bladder infections during this pregnancy? Yes ☐ No ☐
If yes, please explain: _____

Have you had any operations during this pregnancy? Yes ☐ No ☐
If yes, please explain: _____

Have you had any convulsions during this pregnancy? Yes ☐ No ☐
If yes, please explain: _____

Have you had *any* complications during this pregnancy? Yes ☐ No ☐
If yes, please explain: _____

LABOR AND DELIVERY INFORMATION

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

If yes, Doctor's Name/name of practice: _____

Address: _____

Phone w/ area code: _____

If applicable, when did you first see a doctor for prenatal care? _____

How many prenatal visits have you had? _____

How much weight have you gained during pregnancy? _____

Please list all doctors, medical providers, counselors or social workers who have provided treatment or care to you and/or the child (include name, address, and telephone number). Use additional pages if needed

_____

_____

_____

Does your doctor know you are considering adoption? Yes ☐ No ☐

CONDITIONS DURING PREGNANCY OR WITHIN THREE YEARS BEFORE PREGNANCY

Rubella/Measles	Yes ☐	No ☐	Date_____	Treatment_____
Gonorrhea	Yes ☐	No ☐	Date_____	Treatment_____
Vaginal Warts	Yes ☐	No ☐	Date_____	Treatment_____
Virus	Yes ☐	No ☐	Date_____	Treatment_____
Infections	Yes ☐	No ☐	Date_____	Treatment_____
Chlamydia	Yes ☐	No ☐	Date_____	Treatment_____
Herpes	Yes ☐	No ☐	Date_____	Treatment_____
Cytomegalovirus	Yes ☐	No ☐	Date_____	Treatment_____
Parvovirus	Yes ☐	No ☐	Date_____	Treatment_____
Syphilis	Yes ☐	No ☐	Date_____	Treatment_____
Toxoplasmosis	Yes ☐	No ☐	Date_____	Treatment_____
Varicella	Yes ☐	No ☐	Date_____	Treatment_____
Cancer Therapy	Yes ☐	No ☐	Date_____	Treatment_____
HIV/AIDS	Yes ☐	No ☐	Date_____	Treatment_____
Allergies	Yes ☐	No ☐	Date_____	Treatment_____
Hepatitis	Yes ☐	No ☐	Date_____	Treatment_____

MEDICAID INFORMATION

Do you have Medicaid? Yes ☐ No ☐ Pending ☐

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

If yes, what is your Medicaid number? _____

If pending, when did you apply and what is your caseworker's name and phone number?

_____

What state (if other than Indiana) and county is your Medicaid issued through or pending?

_____

Date benefits begin: _____

INSURANCE INFORMATION

Do you have medical insurance coverage? Yes ☐ No ☐

If yes, Company name: _____

Address: _____

Phone Number: _____

Policy Number: _____

If you know, what percentage of medical costs will your insurance company cover for this pregnancy? _____

MEDICATION & DRUG/ALCOHOL USAGE

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

Name of drug: _____
Prescribed for: _____
Length used: _____

Name of drug: _____
Prescribed for: _____
Length used: _____

Name of drug: _____
Prescribed for: _____
Length used: _____

Name of drug: _____
Prescribed for: _____
Length used: _____

Name of drug: _____
Prescribed for: _____
Length used: _____

*Please be very specific as to any drugs or alcohol used during your pregnancy or in the last 5 years, including the frequency 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	None	Used in 3 years prior to pregnancy	Used occasionally (1-5 times) during pregnancy	Used monthly during pregnancy	Used weekly during pregnancy	Used daily during pregnancy
Cigarettes						
Alcohol						
Marijuana						
Cocaine/Crack						
Amphetamines, incl. Meth						
Heroin						
Ecstasy						
Methadone						
LSD						
Stimulants						

Depressants						
Diet Pills						
Tranquilizers						
Anticonvulsants						
Medication for Diabetes						
Heart/Blood Pressure meds						
Pain Relievers, incl aspirin						
Medicine for Convulsions						
Medicine for Nausea						
Antibiotics						
Antihistamines						
Hormones						
Cortisone (ATCH, etc.)						
Medication for Cancer						
Thalidomides						
Nose Drops or Spray						
Barbiturates						
Caffeine (coffee, tea, etc.)						

DRUG & ALCOHOL USAGE	**None**	**Used in 3 years prior to pregnancy**	**Used occasionally (1-5 times) during pregnancy**	**Used monthly during pregnancy**	**Used weekly during pregnancy**	**Used daily during pregnancy**
Aminopterin						
ACE Inhibitors						
Busulfan						
Sleeping pills						
Carbanazepine						
Chlorobiphenyls						
Cyclophosphamide						
Diethylstilbestrol						
Etretinate						
Iodine						
Accutane						
Lithium						
Phenobarbital						
Phenytoin						

Propylthiouracil						
Prostaglandin						
Tetracycline						
Valproic Acid						
Warfarin						
Steroids						
Fertility drugs						
PCP (Angel Dust)						
Vitamin A						
Vitamin D						
Vitamin E						

Did/do either of your parent(s) have a problem with drug or alcohol abuse? Yes ☐ No ☐

If yes, please explain: _____

Does/did this child's father have a problem with drug or alcohol abuse? Yes ☐ No ☐

If yes, please explain: _____

Please list any other medical issues or information about you or your family that were not covered in the information above:

_____

_____

Would you be willing to be contacted in the future if a health problem arises for the child which requires either additional health history, transfusion or an organ transplant?

Yes ☐ No ☐ Comments_____

_____

_____

Birth Mother's Adoption Plan

PREGNANCY AND ADOPTION DECISION

When and how did you first find out that you were pregnant? _____

_____

Where and when do you think you conceived? _____

_____

Does anyone in your family know about your pregnancy? Yes ☐ No ☐

If yes, what are the names and/or relationship to you of those who know of your pregnancy? _____

_____

Does anyone in your family know about your adoption plan? Yes ☐ No ☐

If yes, what are the names and/or relationship to you of those who know of your adoption plan? _____

_____

Of those family members who know of your adoption plan, do any **oppose** your plan of adoption? Yes ☐ No ☐

If yes, what are the names and/or relationship to you of those who oppose your adoption plan? _____

_____

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

_____

Describe your feelings and the reasons why you are considering an adoption plan for the child:

_____

_____

_____

What plan, other than adoption, have you considered for this child?

_____

_____

_____

If you have already selected a family, please describe how you made your decision. If you have not selected a family, please describe what traits, attributes, and characteristics the ideal adoptive parents for your child would have: _____

_____

CONTACT WITH THE ADOPTIVE FAMILY OR CHILD AFTER ADOPTION

What are your hopes and wishes for the child's future?

_____

_____

What is your current feeling about being contacted by the child when he/she is an adult?

_____

_____

Note to adoptive parents: The information provided on this form is information the birth mother provided herself unless otherwise noted. Kirsh & Kirsh, P.C., does not attempt to independently verify the information. Therefore, Kirsh & Kirsh, P.C., does not warrant the accuracy of the information but believes that birth mothers universally act in the best interests of their children and, therefore, will provide the most complete and accurate information possible.

NATIVE AMERICAN-INDIAN TRIBAL MEMBERSHIP ADDENDUM

To your knowledge, is there any American Indian heritage in your family? ***(In order to answer "Yes", you must be able to identify the person by name and the particular tribe, of which they were or are a member. Otherwise, answer "No".)*** Yes ☐ No ☐

If you answered "Yes", please provide the person's name, describe the blood relation and tribe (e.g., my father, whose name is _____ having a date of birth of _____, was one-half Arapaho, my maternal grandmother, whose name is _____ having a date of birth of _____, was one-eighth Sioux)_____

_____

Are you a member of any Native American Indian tribe? Yes ☐ No ☐

Do you qualify to be a member of any Native American Indian tribe? Yes ☐ No ☐

If yes, please indicate the tribe, location and your registration, enrollment or registration number: _____

Do you currently or have you ever lived on an American Indian reservation? Yes ☐ No ☐

Are any of your relatives members of any Native American Indian tribes? Yes ☐ No ☐

Do any of your relatives qualify to be members of any Native American Indian tribes?

Yes ☐ No ☐ If yes, please list the relative's name (including maiden or former names), address, registration/enrollment number, and the name and location of the tribe:

_____

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

The above information is true to the best of my knowledge and belief

_____ _____

Signature ***Date***

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