

HEARTFELT ADOPTION AND SURROGACY SERVICES

ADOPTIVE PARENT QUESTIONNAIRE

DATE _____

HUSBAND NAME: _____

WIFE NAME: _____

ADDRESS: _____

Street

City

County

State

Zip

HOME PHONE: () _____

HUSBAND

NAME: _____

TELEPHONE () _____ WORK

() _____ CELL

E-MAIL : _____

EMPLOYER: _____

ADDRESS: _____

POSITION _____ HOW LONG _____

INCOME _____ (ANNUALLY)

RESIDED IN FLORIDA _____ YEARS

BIRTH DATE _____ AGE _____

PLACE OF BIRTH _____

U.S. CITIZEN? YES / NO IF NO, WHERE: _____

RACE _____ ANCESTRY _____

HAIR _____ EYES _____ HEIGHT _____

WEIGHT _____ COMPLEXION _____

HOBBIES/INTERESTS: _____

RELIGION: _____

DATE AND PLACE OF MARRIAGE: _____

HAVE EITHER FILED FOR SEPARATION, DIVORCE, OR
ANNULMENT DURING THIS MARRIAGE? YES NO

WIFE

NAME: _____

MAIDEN NAME: _____

TELEPHONE () _____ WORK

() _____ CELL

E-MAIL : _____

EMPLOYER: _____

ADDRESS: _____

POSITION _____ HOW LONG _____

INCOME _____ (ANNUALLY)

RESIDED IN FLORIDA _____ YEARS

BIRTH DATE _____ AGE _____

PLACE OF BIRTH _____

U.S. CITIZEN? YES / NO IF NO, WHERE: _____

RACE _____ ANCESTRY _____

HAIR _____ EYES _____ HEIGHT _____

WEIGHT _____ COMPLEXION _____

HOBBIES/INTERESTS: _____

RELIGION: _____

IF WIFE EMPLOYED, WILL SHE TAKE A LEAVE OF ABSENCE?

IF SO, HOW LONG?

WHO WILL CARE FOR CHILD AFTER

PLACEMENT? _____

IF HUSBAND AND WIFE ARE OF DIFFERENT RELIGIONS, WHAT

RELIGION WILL CHILD BE RAISED? _____

DRUG & ALCHOL USE BY THE BIRTH MOTHER

PLEASE MARK AN "X" ON WHAT YOU ARE WILLING TO ACCEPT REGARDING THE BIRTH MOTHERS DRUG AND ALCOHOL USUAGE. IF, FOR EXAMPLE YOU DO NOT CHECK ALCOHOL DURING PREGNANCY WE WILL NOT SEND YOUR INFORMATION TO A BIRTH MOTHER THAT INDICATED THEY HAD ONE DRINK OF ALCOHOL. THINK VERY CAREFULLY FOR EACH RESPONSE. IT SHOULD BE NOTED THAT ALL MEDICAL AND HEALTH HISTORY QUESTIONS ARE ANSWERED BY THE BIRTH PARENTS AND VERIFYING THE VALIDITY OF EACH RESPONSE IS SOMETIMES DIFFICULT OR IMPOSSIBLE. IT IS HIGHLY RECOMMENDED THAT ADOPTIVE FAMILIES RESEARCH THE EFFECTS OF SUBSTANCE USAGE THROUGH A QUALIFIED MEDICAL PROFESSIONAL

DRUG & ALCOHOL	1-5 TIMES	MONTHLY	WEEKLY	DAILY
CIGARETTES				
ALCOHOL				
MARIJUANA				
COCAINE				
METHAMPHETAMINE				
HEROIN				
ECSTASY				
METHADONE				
DIET PILLS				
TRANQUILIZERS				
OTHER PLEASE SPECIFY				

BIRTH PARENT MEDICAL & FAMILY HISTORY

MARK AN "X" IF YOU ARE WILLING TO ACCEPT A CHILD WHOSE PARENTS HAVE A MEDICAL OR FAMILY HISTORY OF SUCH DISORDERS. "IMMEDIATE FAMILY" MEANS THE PARENTS OF THE BIOLOGICAL PARENTS.

DISORDERS	BIRTH PARENTS	IMMEDIATE FAMILY
HIV/AIDS		
CANCER		
DIABETES		
MENTAL CONDITION		
PHYSICALCONDITION		
DOWN'S SYNDROME		
DEPRESSED		
BI POLAR		
SCHIZOPHRENIA		
SICKLECELL ANEMIA		
LEUKEMIA		

CEREBRAL PALSY		
*OTHER PLEASE SPECIFY		

*DUE TO THE NUMBER OF DIFFERENT ISSUES IT IS IMPOSSIBLE TO LIST THEM ALL

CONTACT WITH BIRTH PARENTS

- 1. WOULD YOU LIKE TO HAVE CONTACT WITH BIRTH PARENT(S) BEFORE ADOPTION? **YES** **NO**
- 2. WOULD YOU LIKE TO HAVE CONTACT WITH BIRTH PARENT(S) AFTER ADOPTION? **YES** **NO**
- 3. WOULD YOU BE WILLING TO SEND THE BIRTH PARENT(S) UPDATES(LETTERS, PICTURES, ECT.) AFTER THE ADOPTION? **YES** **NO**
- 4. IF SO UP TO WHAT AGE? _____ YEARS
- 5. WOULD YOU LIKE TO RECEIVE PHONE CALLS FROM BIRTH PARENT(S)? **YES** **NO**
- 6.WOULD YOU LIKE TO CONTACT THE BIRTH PARENT(S) DIRECTLY? **YES** **NO**
- 7. WOULD YOU LIKE CONTACT WITH BIRTH PARENT(S) THROUGH THE AGENCY ONLY? **YES** **NO**
- 8.WOULD YOU LIKE TO MEET BIRTH PARENT(S) IN PERSON? **YES** **NO**
- 9.WOULD YOU LIKE TO ATTEND ANY DOCTOR VISITS WITH BIRTH MOM? **YES** **NO**

ADOPTION

HAVE YOU BEEN TURNED DOWN BY AN ADOPTION AGENCY? **YES** **NO**

IF SO NAME OF AGENCY, DATE AND REASON _____

DO YOU HAVE A COMPLETED HOME STUDY(IF YES, PLEASE ATTACH) **YES** **NO**

IF SO PLEASE LIST THE COST OF YOUR HOME STUDY AS WELL AS THE COST OF YOUR POST PLACEMENTS

NAME, ADDRESS AND PHONE NUMBER OF AGENCY OR PERSON DOING HOME STUDY:

WHY ARE YOU SEEKING TO ADOPT A CHILD?

ARE YOU WORKING WITH ANOTHER CHILD PLACING ENTITY AT THIS TIME? IF YES, WHO?

HOW WERE YOU REFERRED TO CHRISTINE WELCH, ESQUIRE?

BACKGROUND INFORMATION

	<u>YES</u>	<u>NO</u>	HUSBAND OR WIFE	EXPLAIN
BEEN IN BANKRUPTCY				
BEEN IN A MENTAL HOSPITAL				
HAD PSYCHOTHERAPY				
EVER BEEN ARRESTED				
RECEIVED HONORABLE DISCHARGE FROM MILITARY				
PLACED A CHILD FOR ADOPTION				
BEEN DENIED CUSTODY BY A COURT				
BEEN PAST DUE ON CHILD SUPPORT				
HAD AN ABUSE INVESTIGATION				

<p>Please staple all documents together and write name(s) on reverse of any photographs. We cannot guarantee the return of any photographs provided.</p>
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- _____ I/WE HAVE ATTACHED PHOTOGRAPH(S) OF MY FAMILY
- _____ I/WE HAVE ATTACHED A COPY OF MY MARRIAGE CERTIFICATE
- _____ I/WE HAVE ATTACHED A COPY OF ANY/ALL DIVORCE DECREES
- _____ I/WE HAVE ATTACHED A COPY OF OUR HOMESTUDY
- _____ I/WE HAVE ATTACHED OUR FAMILY PROFILE

MEDICAL INSURANCE POLICY COVERAGE

NAME OF MEDICAL INSURANCE COMPANY: _____

AT WHAT TIME (BIRTH, TEMPORARY CUSTODY, FINALIZATION) DOES YOUR INSURANCE COVER MEDICAL EXPENSES FOR YOUR BABY? _____

GROUP # OR POLICY # _____

PLEASE ATTACH A COPY OF YOUR MEDICAL CARD (FRONT AND BACK)

Your medical insurance information will need to be released to the hospital after the birth of the baby to cover any medical bills. Every hospital is covered under strict confidentiality provisions and policies to protect your anonymity.