

PARENTS' PROFILE AT A GLANCE

Please complete this form and return it to our office along with your application. **This information will be shown to birth parents giving them preliminary information. Do not place your identifying information on this form unless you want all information given at the onset of your adoption.** Please be concise on comments, as space is limited. Please type or print the information. Thank you.

FIRST NAMES _____

LENGTH OF MARRIAGE _____

NUMBER OF CHILDREN _____

PARENTING PHILOSOPHY _____

CHARACTERISTICS OF ADOPTIVE FAMILY MEMBERS

	HUSBAND	WIFE
Age and/or birth date		
Height		
Weight		
Build		
Hair color		
Eye color		
Birth order		
Siblings		
Personality		
Sense of humor		
Family role		
Most disliked chore		
Education		
Religion		
Occupation		
Favorite date with spouse		
Hobbies/interests		
Favorite color		
Food		
Restaurant		
Dessert		
Ice cream flavor		
Sport to play and/or watch		
Animal/pet		
Music		

	HUSBAND	WIFE
Book		
Author		
Movie		
TV show		
Toy/plaything		
Family activity		
Vacation spot		

CHILDREN IN THE HOME

Age and birth date		
Height		
Weight		
Build		
Hair color		
Eye color		
Birth order		
Adopted Or biological		
Personality		
Sense of humor		
Most disliked chore		
Grade		
Hobbies/interests		
Favorite color		
Food		
Restaurant		
Dessert		
Ice cream flavor		
Sport to play and/or watch		
Animal/pet		
Music		
Book		
Author		
Movie		
TV show		
Toy/plaything		
Family activity		
Vacation spot		

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HEALTH HISTORY

INFORMATION OF ADOPTIVE APPLICANTS

Please make a copy of this form or print two copies so you can each fill one out separately. Thank you.

NAME: _____

MENTAL HEALTH

Have you or anyone in your family received counseling or other mental health treatment? _____ If yes, please provide additional information, including date(s), reason for care, and medications prescribed. _____

PHYSICAL HEALTH

Describe your general health _____

Please check any of the following childhood diseases you have had:

- | | | |
|---|---|--|
| <input type="checkbox"/> Measles | <input type="checkbox"/> Rubella (3 days) | <input type="checkbox"/> Rubella (2 weeks) |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Roseola | <input type="checkbox"/> Asthma | <input type="checkbox"/> Hayfever |
| <input type="checkbox"/> Encephalitis | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Ear infections |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Urinary/bladder infections | | |
| <input type="checkbox"/> Other (specify) _____ | | |

Have you had any major surgeries? If yes, please provide reasons and dates. _____

**HEALTH HISTORY
 SELF, YOUR PARENTS, AND OTHER RELATIVES**

Indicate by checking the appropriate box if you or any relatives (for example, your parents, brothers, sisters, aunts, uncles, grandparents, children, etc.), have or have had any of the medical conditions listed below. If yes, please indicate that person's relationship to you and complete the *COMMENTS* section. If a medical condition resulted in death of a family member, please indicate and give the person's approximate age at the time of death in the *COMMENTS* section.

Medical Condition	Yes, No, or Unknown	Relationship To You	Comments
CONGENITAL IMPAIRMENTS Club foot or any orthopedic problem (i.e., flat footed, etc.)			
Harelip (cleft lip) or cleft palate			
Downs Syndrome			
Other chromosome abnormality			
Hydrocephalus			
Muscular Dystrophy			Areas affected and age at onset
Dwarfism			
Spina Bifida			

Medical Condition	Yes, No, or Unknown	Relationship To You	Comments
Congenital heart defect			
Tay-Sachs Disease			
ALLERGIES Eczema or other skin condition			Treatment or medication received
Hay fever			
Medication allergy			To what medication?
Food allergy			To what foods?
EYE, DENTAL, EAR AND DEVELOPMENTAL DISORDERS Blindness, Glaucoma, color blindness, or other visual problems			
Corrective glasses or contact lenses			At what age were prescription lenses necessary?
Farsighted or nearsighted			
Astigmatism (inability to focus)			
Strabismus (cross-eye)			
Other (explain)			
Braces on teeth or other orthodontic work			What orthodontic work and for how long?
Deafness or other ear problems			Special education? Age at onset
Speech problems			Special education? Age at onset

Medical Condition	Yes, No, or Unknown	Relationship To You	Comments
Learning disability			Any diagnosis/hospitalization?
Retardation - mental or physical			Any diagnosis/hospitalization?
CIRCULATORY DISORDERS Hemophilia			
Sickle Cell Anemia or trait			
Hypertension (high blood pressure)			Age at onset, what treatment? Hospitalization?
Stroke			Age, treatment?
Heart Attack (coronary)			Age, treatment?
Arthritis			What kind? Age at onset and areas affected
Hepatitis			What type? Age at onset and treatment
Kidney disease			Age at onset and treatment
HORMONAL DISORDERS Diabetes			Age at onset and treatment

Medical Condition	Yes, No, or Unknown	Relationship To You	Comments
Thyroid Disorder			Age at onset and treatment
Obesity (overweight)			Age at onset and treatment
RESPIRATORY DISORDERS Asthma			Treatment
Tuberculosis			What kind and age at onset
Emphysema			Age at onset
MENTAL AND BEHAVIORAL DISORDERS Diagnosed Schizophrenia			Age at onset and treatment. Hospitalization?
Diagnosed Manic Depressive			Treatment
Other mental illness			Describe, using additional paper if necessary
Alcoholism or heavy drinking			Treatment/hospitalization?
Drug usage			Kind, amount and when taken?
LYMPHATIC DISORDERS Cancer			Kind, age at onset, areas affected
Tumors			Kind, age at onset, areas affected

Medical Condition	Yes, No, or Unknown	Relationship To You	Comments
Cystic Fibrosis			Age at onset, areas affected
Hodgkin's Disease			Age at onset, areas affected
NERVOUS SYSTEM DISORDERS Multiple Sclerosis			Age at onset, areas affected
Huntington's Disease			Age at onset, areas affected
Cerebral Palsy			Age at onset
Seizures or convulsions			Frequency, age at onset, what treatment
Epilepsy			Frequency, age at onset, what treatment
INFECTION, HOSPITALIZATION Repeated attacks of fever with known Infection			Diagnosis
Repeated severe infection Necessitating hospitalization			Diagnosis
Hospitalization, operation or injury			When and for what
OTHER MEDICAL OR HEALTH PROBLEMS			Describe

Signature

Date