

# ADOPTIVE FAMILY INTAKE FORM

Telephone \_\_\_\_ Mail \_\_\_\_ E-Mail \_\_\_\_ In-Person \_\_\_\_  
Referred by \_\_\_\_\_

Date \_\_\_\_\_

Name(s) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone Numbers H \_\_\_\_\_ W \_\_\_\_\_

Other \_\_\_\_\_

E-Mail Address \_\_\_\_\_

If couple, length of relationship: \_\_\_\_\_

## ADOPTIVE PARENT 1

Gender \_\_\_\_\_

Age \_\_\_\_\_

Race \_\_\_\_\_

Religion \_\_\_\_\_

Occupation \_\_\_\_\_

## ADOPTIVE PARENT 2

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you have any children? Y N

If yes, circle all that apply: Adopted Birth

How many children? \_\_\_\_\_

Foster Step

Do you have a current adoption home study? Y N

If yes, from where? \_\_\_\_\_

Date approved: \_\_\_\_\_

What type of child do you hope to adopt?

Age range \_\_\_\_\_ Race \_\_\_\_\_ Gender preference: F M E

Are you open to adopting a child with any special needs? Y N M

If yes or maybe, please circle or list: \_\_\_\_\_

Premature Drug exposure Alcohol affected Physical Disability

Cognitive Disability Mental Illness within birth parent(s) / family

Do you have any questions? Y N (If yes, list type of questions caller asked here or on the back of the intake.)

Initials of person taking the intake \_\_\_\_\_

Date application and materials mailed \_\_\_\_\_ initials of person \_\_\_\_\_