

Form completed by: \_\_\_\_\_ Date: \_\_\_\_\_

**Please list everyone living in the child's household**

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Are there siblings not listed above? If so, please list their names, ages, and where they live. \_\_\_\_\_

Are the mother and father: [SINGLE] [MARRIED] [DIVORCED] since: \_\_\_\_\_ remarried since: \_\_\_\_\_

(Only if mom and dad do not live together or does not live with parents) Who has custody of the child/children? \_\_\_\_\_

How often does the child see this parent? \_\_\_\_\_

**Please note the family members that have/had any of the illnesses listed below.**

	Yes or No	Who? (Maternal or Paternal?)	Alive or Deceased (when?)
Diabetes before 50			
High blood pressure			
Asthma			
Heart Disease			
Cancer			
Sickle Cell Anemia			
Stroke			
Heart Attack before 50			
High Cholesterol			
Tuberculosis			
Anemia			
Bleeding Disorder			
Liver Disease			
Kidney Disease			
Deafness			
Bed-Wetting after 10			
Epilepsy or Convulsions			
Alcohol Abuse			
Drug Abuse			
Mental Illness			
Mental Retardation			
Immune Issues, HIV or AIDs			
Other:			