Northeast Ohio Women's Center
(330) 923-4009
www.northeastohioabortion.com

Patient Label

Patient Intake Abortion Questions

Please take a few moments to answer the questions below. Remember, any answers you choose are ok – we're here to support you.

I would like to learn more about how abortion is done.	Yes	Maybe	No	
I'm scared that having an abortion is dangerous.	Yes	Maybe	No	
I'm afraid it will hurt.	Yes	Maybe	No	
I'm wondering what the pregnancy looks like- how developed it is.	Yes	Maybe	No	
I'm worried that I won't be able to have children later if I want to.	Yes	Maybe	No	
I am not sure if I am making the right decision.	Yes	Maybe	No	
I know I will regret having an abortion.	Yes	Maybe	No	
I would like to know more about your adoption services.	Yes	Maybe	No	
Someone is forcing me or pushing me to have an abortion.	Yes	Maybe	No	
I am pregnant as a result of sexual assault.	Yes	Maybe	No	

Other:_____

How are you feeling today? (Circle all that apply)

confident angry happy trapped relieved afraid mean strong worried

curious relaxed sad guilty peaceful ashamed numb resolved

Consultation notes:

Patient signature _____ Date _____

Advocate initials _____ Date _____