

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

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 _____