SUPPORT
AFTER ABORTION
www.SupportAfterAbortion.com

Sample Intake Form

Reproductive losses you've experienced or that impacted you:

(Check all that apply)

- ◯ Miscarriages
- ◯ Abortions
- ◯ Stillbirths
- ◯ Infant/child deaths
- ◯ Adoption placements
- ◯ Infertility
- ◯ Children removed from the home
- ◯ Abortion pill reversal failures
- ◯ None of the above

Types of abortions you've experienced/been impacted by:

- ◯ Medication - with clinic/medical assistance
- ◯ Medication - without clinic/medical assistance
- ◯ Surgical

Date of your most recent reproductive loss: ___/___/___

Date of your most recent abortion: ___/___/___

Are you, or have you in the past, experienced any of the following?

(Check all that apply)

- ◯ Depression
- ◯ Shame
- ◯ Anger
- ◯ Guilt
- ◯ Nightmares
- ◯ Substance Abuse
- ◯ Anxiety
- ◯ Difficulty with relationships
- ◯ Difficulty seeing other children
- ◯ Heightened emotion around the anniversary date of your loss
- ◯ Other - specify _____

Are you currently, or have you in the past, had suicidal thoughts?

If you are having suicidal thoughts now, please call 988.

◯ Yes, currently ◯ Yes, in the past ◯ No

Have you received help for your losses through therapy, counseling, or healing programs?

◯ Yes ◯ No

Are you currently in therapy?

◯ Yes ◯ No

If you're in therapy, does your therapist support your participation in a support group?

◯ Yes ◯ No