Sample Intake Questions

SUPPORT
AFTER ABORTION

How many pregnancies have you experienced?

What was the outcome of each pregnancy?

Have you experienced (or been impacted by) any of these situations?
(Check all that apply)

- ◯ Live births
- ◯ Miscarriages
- ◯ Stillbirths
- ◯ Abortions
- ◯ Infant/child deaths
- ◯ Infertility
- ◯ Children removed from the home
- ◯ Adoption placements
- ◯ None of the above

Date and type of your most recent *<insert each experience>*:

Types of abortions you've experienced/been impacted by:
(Check all that apply)

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

Are you, or have you in the past, experienced any of the following?
(Check all that apply)

- ◯ Depression
- ◯ Anxiety
- ◯ Anger
- ◯ Guilt
- ◯ Nightmares / Flashbacks
- ◯ Substance Abuse
- ◯ Difficulty seeing children
- ◯ Difficulty with relationships
- ◯ Desire to quickly have another baby
- ◯ Heightened emotion around certain dates/milestones or holidays
- ◯ Other - specify _____

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

If you are having suicidal thoughts now, please call 988, the National Suicide & Crisis Lifeline

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

Have you received help for your reproductive experience(s) through therapy, counseling, or support groups?

◯ Yes ◯ No

Are you currently in therapy?

◯ Yes ◯ No

© Support After Abortion