



Client Name: _____ Date: _____

Welcome to WHC Portage. Your comments are important to us. Any information you choose to share will help us provide you with the best possible care today. We respect your choice to not answer any question. We keep all client information confidential.

How do you feel about having an abortion today?

Check any concerns you have today:

- | | |
|--|--|
| <input type="checkbox"/> Not sure about my decision | <input type="checkbox"/> Confidentiality |
| <input type="checkbox"/> Relationship with partner | <input type="checkbox"/> Not sure about other options |
| <input type="checkbox"/> Religious teachings/beliefs | <input type="checkbox"/> Relationship with family |
| <input type="checkbox"/> Pain during/after the procedure | <input type="checkbox"/> Sexual assault |
| <input type="checkbox"/> Possible effects on future pregnancy | <input type="checkbox"/> Emotional feelings afterwards |
| <input type="checkbox"/> Possible complications during/after an abortion | <input type="checkbox"/> No concerns |
| <input type="checkbox"/> Other: _____ | |

Please rate your anxiety from 1 to 5: (not nervous) 1 2 3 4 5 (very nervous)

Would you like information on birth control (BC) or protection from sexually transmitted infections (STI's):

- | | | |
|---|---|--|
| <input type="checkbox"/> Birth control pills | <input type="checkbox"/> Sample of BC/BC prescription | <input type="checkbox"/> Birth control patch |
| <input type="checkbox"/> Vaginal ring | <input type="checkbox"/> Injection (Depo Provera) | <input type="checkbox"/> IUD/IUS |
| <input type="checkbox"/> Condoms (internal or external) | <input type="checkbox"/> Contraceptive film/foam | <input type="checkbox"/> Not sure |
| <input type="checkbox"/> Emergency contraception | <input type="checkbox"/> Other: _____ | |

If this is a multiple pregnancy, would you like to be informed?

- Yes No

I have made a decision to have an abortion today

- Yes No