

*Post Abortion Treatment & Healing*

CLIENT INFORMATION SHEET / INTAKE FORM / BIBLE STUDY

The purpose of this questionnaire is twofold. First, we need some background information on you to help us better understand how we can best help you. Secondly, answering these questions will begin an important process of remembering for you. The questionnaire will be fairly difficult the longer it has been since your abortion (s) as most post-abortion women would rather “forget” the details. So, don’t try to finish it all in one sitting.

Name: \_\_\_\_\_ Today’s Date \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email address: \_\_\_\_\_ Cellphone: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Marital Status: \_\_\_\_\_

CHILDREN:

Name	Age	Sex	With whom do they live?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(can use the back of this form for additional children)

Highest Grade Completed \_\_\_\_\_ College Degree \_\_\_\_\_

Ethnicity (circle): Caucasian Black Asian Hispanic Other

Give an outline of your religious training as a child: \_\_\_\_\_

Are you presently affiliated with any religious organization? \_\_\_\_\_

While you were growing up, did any of your family have any of the following problems?

Problem:	GRANDPARENT (which)	PARENT (which)	Sibling
Alcohol	_____	_____	_____
Drugs	_____	_____	_____
Legal	_____	_____	_____
Emotional illness	_____	_____	_____
Medical illness	_____	_____	_____
Financial	_____	_____	_____

**Impact of Life Circumstances: (Please circle all that apply).**

Losses: Death of spouse, child, father, mother, sister, brother, grandmother, grandfather, friend. Divorce, separation, broken engagement, suicide, miscarriage, abortion, infertility, bankruptcy, homelessness, career or job loss. Other: \_\_\_\_\_

Trauma History: Child abuse: physical, emotional, sexual, incest  
Spouse abuse: physical, emotional, sexual  
Abandonment, Rape, Robbery, Assault, Suicide attempt,  
Auto Accident, Major illness, Surgery, Physical  
Disability, Alienation, other: \_\_\_\_\_

Current Problems: relationship with spouse, children, parents, in laws, co workers, friends, alcohol, drugs, prescription drugs, binge eating, excessive dieting/exercise, shopping too much, working too much, procrastination, communication, anger, depression, grief, gender identity, sex, career, loneliness, mood swings, stress, self-esteem, co-dependency, fear, anxiety, feelings about church or God.  
Other: \_\_\_\_\_

Name: \_\_\_\_\_

**ABORTION(S) HISTORY:** Almost 50% of women who abort today have had two or more abortions. PLEASE do not hesitate to ask the PATH leader for extra copies of this page in order to fill out a history of EACH abortion. We understand that many details may be difficult to remember – especially if you had more than one abortion. Just do the best you can and you will remember more as the group progresses.

Approximate date of abortion: \_\_\_\_\_ Your age at the time: \_\_\_\_\_

What was your marital status at the time? \_\_\_\_\_

How many weeks along were you? \_\_\_\_\_ Type of abortion: \_\_\_\_\_

Abortion performed in a clinic or private M.D's office? \_\_\_\_\_

Check any of the following that have applied to your immediately following your abortion and within the past six months:

<u>Symptom</u>	<u>Immediately after abortion</u>	<u>past 6 months</u>
Guilt	_____	_____
Emotionally "numb"	_____	_____
Dreams/Nightmares	_____	_____
Change in Relationships	_____	_____
Inferiority feelings	_____	_____
Dizziness/Fainting	_____	_____
Sleep Disturbances	_____	_____
Can't make friends	_____	_____
Sexual problems	_____	_____
Preoccupation with abortion date	_____	_____
Preoccupation with due date	_____	_____
Relief	_____	_____
Depressed	_____	_____
Sad	_____	_____
Anxiety	_____	_____
Suicidal ideas	_____	_____
Sedatives	_____	_____
Alcohol/Drugs	_____	_____
Lonelieness	_____	_____
Sense of Loss	_____	_____
Infertility	_____	_____
Sighing	_____	_____
Crying Spells	_____	_____
Regret	_____	_____
Angry	_____	_____
Helplessness	_____	_____
Headaches	_____	_____
Eating disorder	_____	_____
Panic feelings	_____	_____
Unable to relax	_____	_____
Marital Stress	_____	_____
Fatigue	_____	_____
Shame	_____	_____

Have you ever sought counseling for the pain connected with your abortion? \_\_\_\_\_

Were you helped? \_\_\_\_\_

What was beneficial in the help you received? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you ever had medication prescribed (e.g. antidepressants) and/or been hospitalized in an effort to control any symptoms? \_\_\_\_\_

If "yes", please give details: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Did you feel you were adequately counseled and informed before the abortion?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If not, what do you wish you had had in the way of counseling? (Check all that apply.)

- \_\_\_\_\_ more information on fetal development
- \_\_\_\_\_ more sensitivity to how I was feeling
- \_\_\_\_\_ more information about the abortion procedure
- \_\_\_\_\_ (other): \_\_\_\_\_

At the time, who knew about your abortion? \_\_\_\_\_

\_\_\_\_\_

At the time, did you feel pressured into having the abortion? \_\_\_\_\_

By whom? \_\_\_\_\_

What do you think would have been a SIGNIFICANT factor in helping you make a decision to keep the pregnancy? (Check all that apply.)

- \_\_\_\_\_ support from boyfriend/husband/parents/friends
- \_\_\_\_\_ a pro-life center which offers emotional and practical support for a decision to keep the baby
- \_\_\_\_\_ knowing more about the abortion procedure
- \_\_\_\_\_ Knowing more about what fetus looked like
- \_\_\_\_\_ being warned about possible emotional after effects
- \_\_\_\_\_ (other): \_\_\_\_\_

Did your relationship with the male involved in the pregnancy continue after the procedure? \_\_\_\_\_

Describe how the relationship was affected by the abortion: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Did you experience any physical complications resulting from the procedure (hemorrhage, infection, high fever, perforated uterus, intense cramping, incomplete abortion, etc)? \_\_\_\_\_

Please explain: \_\_\_\_\_

---

---

---

If you are a Christian, do you feel God has forgiven you for this Abortion? \_\_\_\_\_

Do you feel you have forgiven yourself? \_\_\_\_\_

---

---

---

State, in your own words, why you want to attend the PATH group: \_\_\_\_\_

---

---

---

*Thank you for taking the time to fill this out! God bless and keep you!*