CHOICES.
Memphis Center for Reproductive Health

PT #: _____
DOB: _____
Name: _____

PATIENT CONCERNS

This form will help your Educator and Clinician provide you with a holistic experience during your visit.

Feelings about abortion *Please check all that apply*

___ I am 100% sure of my decision concerning the procedure today.

___ I am conflicted about the decision to have an abortion.

___ I am NOT sure of my decision concerning the procedure today. I would like to discuss abortion alternatives.

Please, in as many words as you need, describe how you feel about your decision to terminate your pregnancy. _____
_____

Is anyone pressuring you to have an abortion? **YES / NO**

I understand that it is against the law for anyone, regardless of the person's relationship to me, to coerce me to have an abortion against my will. An abortion cannot be performed on me unless I have freely given voluntary and informed consent. I have the right to contact a local or state law enforcement agency to receive protection from any actual or threatened criminal offense to coerce an abortion.

Reproductive Life Goals

Would you like to have a child (or additional children) in the future? **YES / NO / NOT SURE**

If yes:

What age would you like to be when you have your first (next) child? _____

If you would like to have more than one child, how many years apart would you like for them to be? _____

Do you have a plan to prevent pregnancy until you are ready? **YES / NO**

If no:

Do you have a plan to prevent pregnancy? **YES / NO**

Other Health Risks *So that we may better serve you, please answer the following questions honestly.*

Within the past year have you been hit, slapped, kicked or otherwise physically hurt by someone? **YES / NO**

Are you in a relationship with a person who threatens or physically hurt you? **YES / NO**

Has anyone forced you to have sexual activities that made you feel uncomfortable? **YES / NO**

Adapted from the American Congress of Obstetricians and Gynecologist (ACOG)
Retrieved from http://www.acog.org/About_ACOG/ACOG_Departments/Violence_Against_Women/Screening_Tools_Domestic_Violence

Referrals

Do you feel overwhelmed with financial responsibilities, bills, utilities, housing payments, etc.? **YES / NO**

Do you feel frustrated with parenting challenges and other family relationship issues? **YES / NO**

Patient Signature:_____Date:_____

Patient Concern(s): _____

CHOICES Staff: _____Date:_____