Client Intake ~ Pregnancy Test/Early Pregnancy Consultation

CASE NO. T_____

RECEPTIONIST

Confidential Client Information

Name: last: _____ first: _____ Date: ____/____/____

Address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ cell phone: _____ Date of birth: _____ Age: _____

Referral source: _____ Lay counselor: _____

LAY COUNSELOR

Personal Facts

Marital status: ☐ married ☐ single ☐ other: _____

Living arrangements: ☐ parents ☐ husband ☐ roommate ☐ boyfriend ☐ children ☐ alone

Religion: _____

Occupation: _____ Student: ☐ yes - level: _____ ☐ no

Insurance: _____

Menstrual History

1st day of last period: _____ Was it normal? ☐ yes ☐ no Are periods regular? ☐ yes ☐ no

Using contraceptives? ☐ yes ☐ no If yes, what type: _____

Pregnancy Symptoms

☐ nausea ☐ appetite change ☐ swollen breasts ☐ sore breasts ☐ fatigue
☐ dizziness ☐ frequent urination ☐ weight loss/gain ☐ moodiness/irritability

Previous Pregnancies

Carried to term: # _____ date (s): _____
Miscarriages: # _____ date (s): _____
Abortions: # _____ date (s): _____

If aborted, what physical or emotional effects? _____

Intentions

If pregnant, what are your intentions?
☐ carry to term ☐ abort ☐ undecided

If you were to carry to term, would you be interested in:
☐ adoption ☐ parenting ☐ undecided

What are your general feelings about abortion?
☐ for ☐ against ☐ unsure ☐ ok for others, not me

How would the child's father be involved? _____ Child's father: _____ Age: _____ Occupation: _____

Explanation of Services

The pregnancy test offered here is 99% accurate. This is a test only not a diagnosis.
The workers at this pregnancy help center are volunteers who have receive training in pregnancy consultation. These volunteers, for the most part, d not have degrees in counseling, nor are they licensed by the state. The assis tance provided here is not intended as a substitute for professional counse ing. We offer information, emotional and spiritual support, and practica help. The information given is NOT a medical diagnosis. We advise yo to consult your doctor for an actual diagnosis of pregnancy and relate health matters.

I understand the above paragraph and give my permission for these services

Client's Signature: _____

Date: _____

Pregnancy Test

Test Results: (+) (-)

Estimated due date: _____

Test done elsewhere: (+) (-) _____ Date: _____

_____

Retest (+) (-) Lay counselor's initials: ____ Date: _____

Client Concerns

How do you feel about the test results? _____
What are your concerns? _____
If positive test, whom will you involve in decision making? _____

Follow Up Plan

May we contact you? ☐ yes ☐ no Notes (preferred telephone #, etc.): _____
_____
_____
_____

Interested in returning for: ☐ retest ☐ layette ☐ bring baby for gift
☐ Loving Moms ☐ post abortion support

Lay Counselor's Observations

Items given: ☐ test verification ☐ business card ☐ booties

Pamphlets: _____
_____

Referrals: _____
_____

Audio visuals: _____
_____

Summary of Situation

_____
_____
_____
_____
_____
_____
_____
_____

Follow up Notes

Date: _____ lay counselor's name: _____
Comments: _____
_____

Date: _____ lay counselor's name: _____
Comments: _____
_____

Date: _____ lay counselor's name: _____
Comments: _____
_____