Post - Abortion Stress Test

Answer “Y” for yes and “N” for no.

1. _____ Do you find yourself struggling to turn off the feelings connected to your abortion(s) perhaps telling yourself over and over to forget about it?

2. _____ Are you affected by physical reminders of your abortion, i.e., babies, pregnant women, sound of vacuum; or are you uncomfortable around children?

3. _____ Have you experienced a desire to be pregnant again, perhaps wishing to replace your aborted child?

4. _____ Have you experienced any new or increased self-destructive behaviors (promiscuity, abusive relationships, eating disorders, drug / alcohol abuse)?

5. _____ Have you experienced any reactions such as nightmares, flashbacks, or hallucinations (such as hearing a baby cry) that relate to your abortion experience?

6. _____ Have you experienced periods of prolonged depression?

7. _____ Have you had any suicidal thought since your abortion(s)?

8. _____ Are you able to talk about your abortion(s)?

9. _____ Do you fear that you will never be able to have children, or more children?

10. ____ Do you tend to look at your life in terms of “before” and “after” the abortion?

11. ____ Have you experienced a numbing of your emotions – an inability to feel strongly?

12. ____ Do you feel sad or depressed on the anniversary date of the abortion or the anniversary of the due date of the baby?

13. ____ Are you bothered by feelings of guilt or shame?

14. ____ Do you grieve for the loss of your baby?

15. ____ Are you having trouble forgiving others who were involved in the decision to abort or in your abortion(s)?

16. ____ Do you have mothering problems with any of your living children (for example, over-protective, difficulty with physical affection, failure to bond, etc.)?

Client Name: _____ Client D.O.B. ____/____/_____ Client Number: _____