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FOR OFFICE USE ONLY

Patient Name _____

Case # _____

Date of visit: _____ Staff/Volunteer Name:_____

HOPE WOMEN'S CENTERS

*** EXTREMELY CONFIDENTIAL INFORMATION ***

# PATIENT STORY FORM

Baby's Name_____Date of Baby's Birth_____

Client Signature granting permission to use story: **X**_____

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**How did you feel when your pregnancy test was positive? What were some of the thoughts going through your mind at the time?**

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**What pressures did you face as you thought about having a baby? What were some of the obstacles you were concerned about?**

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**Did your visit to Hope influence the decision you made to carry your baby to term? Or were there other circumstances and people influencing you at the time?**

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**Can you identify one thing that helped you have the courage to choose life?**

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**Is there anything else you would like to share about your experience at Hope.**
*(If you need more space for any of your answers, you can use the back of the page.)*