

# Edinburgh Postnatal Depression Scale<sup>1</sup> (EPDS)

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

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

Your Date of Birth: \_\_\_\_\_

Baby's Date of Birth: \_\_\_\_\_

Phone: \_\_\_\_\_

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:

- Yes, all the time
- Yes, most of the time      This would mean: "I have felt happy most of the time" during the past week.
- No, not very often      Please complete the other questions in the same way.
- No, not at all

In the past 7 days:

- |  |  |
|--|--|
| <p>1. I have been able to laugh and see the funny side of things</p> <ul style="list-style-type: none"><li><input type="checkbox"/> As much as I always could</li><li><input type="checkbox"/> Not quite so much now</li><li><input type="checkbox"/> Definitely not so much now</li><li><input type="checkbox"/> Not at all</li></ul> <p>2. I have looked forward with enjoyment to things</p> <ul style="list-style-type: none"><li><input type="checkbox"/> As much as I ever did</li><li><input type="checkbox"/> Rather less than I used to</li><li><input type="checkbox"/> Definitely less than I used to</li><li><input type="checkbox"/> Hardly at all</li></ul> <p>*3. I have blamed myself unnecessarily when things went wrong</p> <ul style="list-style-type: none"><li><input type="checkbox"/> Yes, most of the time</li><li><input type="checkbox"/> Yes, some of the time</li><li><input type="checkbox"/> Not very often</li><li><input type="checkbox"/> No, never</li></ul> <p>4. I have been anxious or worried for no good reason</p> <ul style="list-style-type: none"><li><input type="checkbox"/> No, not at all</li><li><input type="checkbox"/> Hardly ever</li><li><input type="checkbox"/> Yes, sometimes</li><li><input type="checkbox"/> Yes, very often</li></ul> <p>*5. I have felt scared or panicky for no very good reason</p> <ul style="list-style-type: none"><li><input type="checkbox"/> Yes, quite a lot</li><li><input type="checkbox"/> Yes, sometimes</li><li><input type="checkbox"/> No, not much</li><li><input type="checkbox"/> No, not at all</li></ul> | <p>*6. Things have been getting on top of me</p> <ul style="list-style-type: none"><li><input type="checkbox"/> Yes, most of the time I haven't been able to cope at all</li><li><input type="checkbox"/> Yes, sometimes I haven't been coping as well as usual</li><li><input type="checkbox"/> No, most of the time I have coped quite well</li><li><input type="checkbox"/> No, I have been coping as well as ever</li></ul> <p>*7. I have been so unhappy that I have had difficulty sleeping</p> <ul style="list-style-type: none"><li><input type="checkbox"/> Yes, most of the time</li><li><input type="checkbox"/> Yes, sometimes</li><li><input type="checkbox"/> Not very often</li><li><input type="checkbox"/> No, not at all</li></ul> <p>*8. I have felt sad or miserable</p> <ul style="list-style-type: none"><li><input type="checkbox"/> Yes, most of the time</li><li><input type="checkbox"/> Yes, quite often</li><li><input type="checkbox"/> Not very often</li><li><input type="checkbox"/> No, not at all</li></ul> <p>*9. I have been so unhappy that I have been crying</p> <ul style="list-style-type: none"><li><input type="checkbox"/> Yes, most of the time</li><li><input type="checkbox"/> Yes, quite often</li><li><input type="checkbox"/> Only occasionally</li><li><input type="checkbox"/> No, never</li></ul> <p>*10. The thought of harming myself has occurred to me</p> <ul style="list-style-type: none"><li><input type="checkbox"/> Yes, quite often</li><li><input type="checkbox"/> Sometimes</li><li><input type="checkbox"/> Hardly ever</li><li><input type="checkbox"/> Never</li></ul> |
|--|--|

Administered/Reviewed by \_\_\_\_\_ Date \_\_\_\_\_

<sup>1</sup>Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786 .

<sup>2</sup>Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

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# Edinburgh Postnatal Depression Scale<sup>1</sup> (EPDS)

Postpartum depression is the most common complication of childbearing.<sup>2</sup> The 10-question Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk for "perinatal" depression. The EPDS is easy to administer and has proven to be an effective screening tool.

Mothers who score above 13 are likely to be suffering from a depressive illness of varying severity. The EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt *during the previous week*. In doubtful cases it may be useful to repeat the tool after 2 weeks. The scale will not detect mothers with anxiety neuroses, phobias or personality disorders.

Women with postpartum depression need not feel alone. They may find useful information on the web sites of the National Women's Health Information Center <[www.4women.gov](http://www.4women.gov)> and from groups such as Postpartum Support International <[www.chss.iup.edu/postpartum](http://www.chss.iup.edu/postpartum)> and Depression after Delivery <[www.depressionafterdelivery.com](http://www.depressionafterdelivery.com)>.

## SCORING

### QUESTIONS 1, 2, & 4 (without an \*)

Are scored 0, 1, 2 or 3 with top box scored as 0 and the bottom box scored as 3.

### QUESTIONS 3, 5-10 (marked with an \*)

Are reverse scored, with the top box scored as a 3 and the bottom box scored as 0.

Maximum score: 30

Possible Depression: 10 or greater

Always look at item 10 (suicidal thoughts)

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## Instructions for using the Edinburgh Postnatal Depression Scale:

1. The mother is asked to check the response that comes closest to how she has been feeling in the previous 7 days.
2. All the items must be completed.
3. Care should be taken to avoid the possibility of the mother discussing her answers with others. (Answers come from the mother or pregnant woman.)
4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.

<sup>1</sup>Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786.

<sup>2</sup>Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199



# Ages & Stages Questionnaires®

## 2 Month Questionnaire

1 month 0 days through 2 months 30 days

Please provide the following information. Use black or blue ink only and print legibly when completing this form.



Date ASQ completed: \_\_\_\_\_

### Baby's information

Baby's first name: \_\_\_\_\_ Middle initial: \_\_\_\_\_ Baby's last name: \_\_\_\_\_

Baby's date of birth: \_\_\_\_\_ If baby was born 3 or more weeks prematurely, # of weeks premature: \_\_\_\_\_ Baby's gender:  Male  Female

### Person filling out questionnaire

First name: \_\_\_\_\_ Middle initial: \_\_\_\_\_ Last name: \_\_\_\_\_

Street address: \_\_\_\_\_

Relationship to baby:

Parent  Guardian  Teacher  Child care provider

Grandparent or other relative  Foster parent  Other: \_\_\_\_\_

City: \_\_\_\_\_ State/Province: \_\_\_\_\_ ZIP/Postal code: \_\_\_\_\_

Country: \_\_\_\_\_ Home telephone number: \_\_\_\_\_ Other telephone number: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Names of people assisting in questionnaire completion: \_\_\_\_\_

### Program Information

Baby ID #: \_\_\_\_\_ Age at administration in months and days: \_\_\_\_\_

Program ID #: \_\_\_\_\_ If premature, adjusted age in months and days: \_\_\_\_\_

Program name: \_\_\_\_\_



# 2 Month Questionnaire

1 month 0 days  
through 2 months 30 days

On the following pages are questions about activities babies may do. Your baby may have already done some of the activities described here, and there may be some your baby has not begun doing yet. For each item, please fill in the circle that indicates whether your baby is doing the activity regularly, sometimes, or not yet.

### Important Points to Remember:

- Try each activity with your baby before marking a response.
- Make completing this questionnaire a game that is fun for you and your baby.
- Make sure your baby is rested and fed.
- Please return this questionnaire by \_\_\_\_\_.

### Notes:

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## COMMUNICATION

	YES	SOMETIMES	NOT YET	
1. Does your baby sometimes make throaty or gurgling sounds?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
2. Does your baby make cooing sounds such as "ooo," "gah," and "aah"?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
3. When you speak to your baby, does she make sounds back to you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
4. Does your baby smile when you talk to him?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
5. Does your baby chuckle softly?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
6. After you have been out of sight, does your baby smile or get excited when she sees you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___

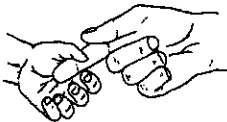


COMMUNICATION TOTAL \_\_\_\_\_

## GROSS MOTOR

	YES	SOMETIMES	NOT YET	
1. While your baby is on his back, does he wave his arms and legs, wiggle, and squirm?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
2. When your baby is on her tummy, does she turn her head to the side?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
3. When your baby is on his tummy, does he hold his head up longer than a few seconds?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
4. When your baby is on her back, does she kick her legs?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
5. While your baby is on his back, does he move his head from side to side?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
6. After holding her head up while on her tummy, does your baby lay her head back down on the floor, rather than let it drop or fall forward?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___

GROSS MOTOR TOTAL \_\_\_\_\_


**FINE MOTOR**

- |   | YES   | SOMETIMES             | NOT YET               |      |
|---|---|-----------------------|-----------------------|------|
| 1. Is your baby's hand usually tightly closed when he is awake? (If your baby used to do this but no longer does, mark "yes.")    | <input type="radio"/>   | <input type="radio"/> | <input type="radio"/> | ___  |
| 2. Does your baby grasp your finger if you touch the palm of her hand?  | <input type="radio"/>   | <input type="radio"/> | <input type="radio"/> | ___  |
|   |  |                       |                       |      |
| 3. When you put a toy in his hand, does your baby hold it in his hand briefly?  | <input type="radio"/>   | <input type="radio"/> | <input type="radio"/> | ___  |
|   |  |                       |                       |      |
| 4. Does your baby touch her face with her hands?  | <input type="radio"/>   | <input type="radio"/> | <input type="radio"/> | ___  |
| 5. Does your baby hold his hands open or partly open when he is awake (rather than in fists, as they were when he was a newborn)? | <input type="radio"/>   | <input type="radio"/> | <input type="radio"/> | ___* |
|   |  |                       |                       |      |
| 6. Does your baby grab or scratch at her clothes?   | <input type="radio"/>   | <input type="radio"/> | <input type="radio"/> | ___  |

FINE MOTOR TOTAL

*\*If Fine Motor item 5 is marked "yes," mark Fine Motor item 1 as "yes."*

**PROBLEM SOLVING**

- |   | YES   | SOMETIMES             | NOT YET               |     |
|---|---|-----------------------|-----------------------|-----|
| 1. Does your baby look at objects that are 8-10 inches away?  | <input type="radio"/>   | <input type="radio"/> | <input type="radio"/> | ___ |
| 2. When you move around, does your baby follow you with his eyes?   | <input type="radio"/>   | <input type="radio"/> | <input type="radio"/> | ___ |
| 3. When you move a toy slowly from side to side in front of your baby's face (about 10 inches away), does your baby follow the toy with her eyes, sometimes turning her head? | <input type="radio"/>   | <input type="radio"/> | <input type="radio"/> | ___ |
| 4. When you move a small toy up and down slowly in front of your baby's face (about 10 inches away), does your baby follow the toy with his eyes?                             | <input type="radio"/>   | <input type="radio"/> | <input type="radio"/> | ___ |
| 5. When you hold your baby in a sitting position, does she look at a toy (about the size of a cup or rattle) that you place on the table or floor in front of her?            | <input type="radio"/>   | <input type="radio"/> | <input type="radio"/> | ___ |
| 6. When you dangle a toy above your baby while he is lying on his back, does he wave his arms toward the toy?   | <input type="radio"/>   | <input type="radio"/> | <input type="radio"/> | ___ |
|   |  |                       |                       |     |

PROBLEM SOLVING TOTAL

**PERSONAL-SOCIAL**

- |  | YES                   | SOMETIMES             | NOT YET               |     |
|--|-----------------------|-----------------------|-----------------------|-----|
| 1. Does your baby sometimes try to suck, even when she's not feeding?                      | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 2. Does your baby cry when he is hungry, wet, tired, or wants to be held?                  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 3. Does your baby smile at you?  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 4. When you smile at your baby, does she smile back?                                       | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 5. Does your baby watch his hands?   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 6. When your baby sees the breast or bottle, does she seem to know she is about to be fed? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |



PERSONAL-SOCIAL TOTAL \_\_\_

**OVERALL**

Parents and providers may use the space below for additional comments.

1. Did your baby pass the newborn hearing screening test? If no, explain:  YES  NO

2. Does your baby move both hands and both legs equally well? If no, explain:  YES  NO

3. Does either parent have a family history of childhood deafness, hearing impairment, or vision problems? If yes, explain:  YES  NO

**OVERALL** (continued)

4. Has your baby had any medical problems? If yes, explain:

YES

NO

[Empty rounded rectangular box for explanation]

5. Do you have concerns about your baby's behavior (for example, eating, sleeping)? If yes, explain:

YES

NO

[Empty rounded rectangular box for explanation]

6. Does anything about your baby worry you? If yes, explain:

YES

NO

[Empty rounded rectangular box for explanation]



# 2 Month ASQ-3 Information Summary

1 months 0 days through  
2 months 30 days

Baby's name: \_\_\_\_\_ Date ASQ completed: \_\_\_\_\_  
 Baby's ID #: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
 Administering program/provider: \_\_\_\_\_ Was age adjusted for prematurity when selecting questionnaire?  Yes  No

**1. SCORE AND TRANSFER TOTALS TO CHART BELOW:** See ASQ-3 User's Guide for details, including how to adjust scores if item responses are missing. Score each item (YES = 10, SOMETIMES = 5, NOT YET = 0). Add item scores, and record each area total. In the chart below, transfer the total scores, and fill in the circles corresponding with the total scores.

Area	Cutoff	Total Score	0	5	10	15	20	25	30	35	40	45	50	55	60
Communication	22.77		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Gross Motor	41.84		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fine Motor	30.16		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Problem Solving	24.62		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Personal-Social	33.71		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**2. TRANSFER OVERALL RESPONSES:** Bolded uppercase responses require follow-up. See ASQ-3 User's Guide, Chapter 6.

- |  |            |           |  |     |    |
|--|------------|-----------|--|-----|----|
| 1. Passed newborn hearing screening test?<br>Comments:       | Yes        | <b>NO</b> | 4. Any medical problems?<br>Comments:    | YES | No |
| 2. Moves both hands and both legs equally well?<br>Comments: | Yes        | <b>NO</b> | 5. Concerns about behavior?<br>Comments: | YES | No |
| 3. Family history of hearing impairment?<br>Comments:        | <b>YES</b> | No        | 6. Other concerns?<br>Comments:          | YES | No |

**3. ASQ SCORE INTERPRETATION AND RECOMMENDATION FOR FOLLOW-UP:** You must consider total area scores, overall responses, and other considerations, such as opportunities to practice skills, to determine appropriate follow-up.

If the baby's total score is in the  area, it is above the cutoff, and the baby's development appears to be on schedule.  
 If the baby's total score is in the  area, it is close to the cutoff. Provide learning activities and monitor.  
 If the baby's total score is in the  area, it is below the cutoff. Further assessment with a professional may be needed.

**4. FOLLOW-UP ACTION TAKEN:** Check all that apply.

- Provide activities and rescreen in \_\_\_\_\_ months.
- Share results with primary health care provider.
- Refer for (circle all that apply) hearing, vision, and/or behavioral screening.
- Refer to primary health care provider or other community agency (specify reason): \_\_\_\_\_
- Refer to early intervention/early childhood special education.
- No further action taken at this time
- Other (specify): \_\_\_\_\_

**5. OPTIONAL:** Transfer item responses (Y = YES, S = SOMETIMES, N = NOT YET, X = response missing).

	1	2	3	4	5	6
Communication						
Gross Motor						
Fine Motor						
Problem Solving						
Personal-Social						