Name _____Date_____
Baby's Age _____ Phone_____

Edinburgh Postnatal Depression Scale (EPDS)

Please take the time to complete this form. We are required by the state of Illinois as pediatricians to administer this questionnaire at various times during your baby's first year. You will be responsible for any charges not covered by your insurance for this screening. We would like to know how you are feeling. Please CHECK the answer which comes closest to how you have felt IN THE PAST 7 DAYS, not just how you feel today.

1. I have been able to laugh and see the funny side of things.

   _ As much as I always could
   _ Not quite so much now
   _ Definitely not so much now
   _ Not at all

2. I have looked forward with enjoyment to things.

   _ As much as I ever did
   _ Rather less than I used to
   _ Definitely less than I used to
   _ Hardly at all

*3. I have blamed myself unnecessarily when things went wrong.

   _ Yes, most of the time
   _ Yes, some of the time
   _ Not very often
   _ No, never

4. I have been anxious or worried for no good reason.

   _ No, not at all
   _ Hardly ever
   _ Yes, sometimes
   _ Yes, very often

*5. I have felt scared or panicky for no very good reason.

   _ Yes, quite a lot
   _ Yes, sometimes
   _ No, not much
   _ No, not at all

*6. Things have been getting on top of me.

   _ Yes, most of the time I haven't been able to cope at all
   _Yes, sometimes I haven't been coping as well as usual
   _ No, most of the time I have been coping quite well
   _ No, I have been coping as well as ever

*7. I have been so unhappy that I have had difficulty sleeping.

   _ Yes, most of the time
   _ Yes, sometimes
   _ Not very often
   _ No, not at all

*8. I have felt sad or miserable.

   _ Yes, most of the time
   _ Yes, quite often
   _ Not very often
   _ No, not at all

*9. I have been so unhappy that I have been crying.

   _ Yes, most of the time
   _ Yes, quite often
   _ Only occasionally
   _ No, never

*10. The thought of harming myself has occurred to me.

   _ Yes, quite often
   _ Sometimes
   _ Hardly ever
   _ Never