

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. 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