

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

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

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

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

\_\_\_\_\_

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

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

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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:

- |   |   |
|---|---|
| 1. I have been able to laugh and see the funny side of things | *6. Things have been getting on top of me   |
| <input type="checkbox"/> As much as I always could            | <input type="checkbox"/> Yes, most of the time I haven't been able to cope at all |
| <input type="checkbox"/> Not quite so much now                | <input type="checkbox"/> Yes, sometimes I haven't been coping as well as usual    |
| <input type="checkbox"/> Definitely not so much now           | <input type="checkbox"/> No, most of the time I have coped quite well             |
| <input type="checkbox"/> Not at all                           | <input type="checkbox"/> No, I have been coping as well as ever                   |
| 2. I have looked forward with enjoyment to things             | *7 I have been so unhappy that I have had difficulty sleeping                     |
| <input type="checkbox"/> As much as I ever did                | <input type="checkbox"/> Yes, most of the time                                    |
| <input type="checkbox"/> Rather less than I used to           | <input type="checkbox"/> Yes, sometimes   |
| <input type="checkbox"/> Definitely less than I used to       | <input type="checkbox"/> Not very often   |
| <input type="checkbox"/> Hardly at all                        | <input type="checkbox"/> No, not at all   |
| *3. I have blamed myself unnecessarily when things went wrong | *8 I have felt sad or miserable   |
| <input type="checkbox"/> Yes, most of the time                | <input type="checkbox"/> Yes, most of the time                                    |
| <input type="checkbox"/> Yes, some of the time                | <input type="checkbox"/> Yes, quite often   |
| <input type="checkbox"/> Not very often                       | <input type="checkbox"/> Not very often   |
| <input type="checkbox"/> No, never                            | <input type="checkbox"/> No, not at all   |
| 4. I have been anxious or worried for no good reason          | *9 I have been so unhappy that I have been crying                                 |
| <input type="checkbox"/> No, not at all                       | <input type="checkbox"/> Yes, most of the time                                    |
| <input type="checkbox"/> Hardly ever                          | <input type="checkbox"/> Yes, quite often   |
| <input type="checkbox"/> Yes, sometimes                       | <input type="checkbox"/> Only occasionally  |
| <input type="checkbox"/> Yes, very often                      | <input type="checkbox"/> No, never  |
| *5 I have felt scared or panicky for no very good reason      | *10 The thought of harming myself has occurred to me                              |
| <input type="checkbox"/> Yes, quite a lot                     | <input type="checkbox"/> Yes, quite often   |
| <input type="checkbox"/> Yes, sometimes                       | <input type="checkbox"/> Sometimes  |
| <input type="checkbox"/> No, not much                         | <input type="checkbox"/> Hardly ever  |
| <input type="checkbox"/> No, not at all                       | <input type="checkbox"/> Never  |

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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# Ages & Stages Questionnaires®

## 6 Month Questionnaire

5 months 0 days through 6 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:	



# 6 Month Questionnaire

5 months 0 days  
through 6 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 make high-pitched squeals?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
2. When playing with sounds, does your baby make grunting, growling, or other deep-toned sounds?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
3. If you call your baby when you are out of sight, does she look in the direction of your voice?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
4. When a loud noise occurs, does your baby turn to see where the sound came from?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
5. Does your baby make sounds like "da," "ga," "ka," and "ba"?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
6. If you copy the sounds your baby makes, does your baby repeat the same sounds back to 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 your baby lift his legs high enough to see his feet?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
2. When your baby is on her tummy, does she straighten both arms and push her whole chest off the bed or floor?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
3. Does your baby roll from his back to his tummy, getting both arms out from under him?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
4. When you put your baby on the floor, does she lean on her hands while sitting? (If she already sits up straight without leaning on her hands, mark "yes" for this item.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___



**GROSS MOTOR** *(continued)*

5. If you hold both hands just to balance your baby, does he support his own weight while standing?



YES	SOMETIMES	NOT YET	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—

6. Does your baby get into a crawling position by getting up on her hands and knees?



<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
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GROSS MOTOR TOTAL —

**FINE MOTOR**

1. Does your baby grab a toy you offer and look at it, wave it about, or chew on it for about 1 minute?

YES	SOMETIMES	NOT YET	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—

2. Does your baby reach for or grasp a toy using both hands at once?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
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3. Does your baby reach for a crumb or Cheerio and touch it with his finger or hand? *(If he already picks up a small object the size of a pea, mark "yes" for this item.)*



<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
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4. Does your baby pick up a small toy, holding it in the center of her hand with her fingers around it?



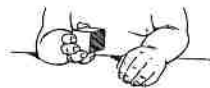
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
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5. Does your baby try to pick up a crumb or Cheerio by using his thumb and all of his fingers in a raking motion, even if he isn't able to pick it up? *(If he already picks up the crumb or Cheerio, mark "yes" for this item.)*



<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
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6. Does your baby pick up a small toy with only one hand?



<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
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FINE MOTOR TOTAL —

**PROBLEM SOLVING**

1. When a toy is in front of your baby, does she reach for it with both hands?

YES	SOMETIMES	NOT YET	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—

2. When your baby is on his back, does he turn his head to look for a toy when he drops it? *(If he already picks it up, mark "yes" for this item.)*

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
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3. When your baby is on her back, does she try to get a toy she has dropped if she can see it?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
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—

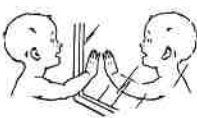



**PROBLEM SOLVING** (continued)

YES                      SOMETIMES                      NOT YET

- |  |   |                       |                       |                       |   |
|--|---|-----------------------|-----------------------|-----------------------|---|
| 4. Does your baby pick up a toy and put it in his mouth?                   |  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 5. Does your baby pass a toy back and forth from one hand to the other?    |  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 6. Does your baby play by banging a toy up and down on the floor or table? |  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| PROBLEM SOLVING TOTAL  |   |                       |                       |                       | — |

**PERSONAL-SOCIAL**

YES                      SOMETIMES                      NOT YET

- |   |   |                       |                       |                       |   |
|---|---|-----------------------|-----------------------|-----------------------|---|
| 1. When in front of a large mirror, does your baby smile or coo at herself?   |    | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 2. Does your baby act differently toward strangers than he does with you and other familiar people? (Reactions to strangers may include staring, frowning, withdrawing, or crying.) |   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 3. While lying on her back, does your baby play by grabbing her foot?   |  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 4. When in front of a large mirror, does your baby reach out to pat the mirror?   |  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 5. While your baby is on his back, does he put his foot in his mouth?   |  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | — |
| 6. Does your baby try to get a toy that is out of reach? (She may roll, pivot on her tummy, or crawl to get it.)  |   | <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. Does your baby use both hands and both legs equally well? If no, explain:  YES  NO

2. When you help your baby stand, are his feet flat on the surface most of the time? If no, explain:  YES  NO

3. Do you have concerns that your baby is too quiet or does not make sounds like other babies? If yes, explain:  YES  NO

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

5. Do you have concerns about your baby's vision? If yes, explain:  YES  NO

6. Has your baby had any medical problems in the last several months? If yes, explain:

YES

NO

7. Do you have any concerns about your baby's behavior? If yes, explain:

YES

NO

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

YES

NO



# 6 Month ASQ-3 Information Summary

5 months 0 days through  
6 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	29.65		●	●	●	●	●	●	○	○	○	○	○	○	○
Gross Motor	22.25		●	●	●	●	●	○	○	○	○	○	○	○	○
Fine Motor	25.14		●	●	●	●	●	○	○	○	○	○	○	○	○
Problem Solving	27.72		●	●	●	●	●	○	○	○	○	○	○	○	○
Personal-Social	25.34		●	●	●	●	●	○	○	○	○	○	○	○	○

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

- |  |               |  |               |
|--|---------------|--|---------------|
| 1. Uses both hands and both legs equally well?<br>Comments:    | Yes <b>NO</b> | 5. Concerns about vision?<br>Comments:   | <b>YES</b> No |
| 2. Feet are flat on the surface most of the time?<br>Comments: | Yes <b>NO</b> | 6. Any medical problems?<br>Comments:    | <b>YES</b> No |
| 3. Concerns about not making sounds?<br>Comments:              | <b>YES</b> No | 7. Concerns about behavior?<br>Comments: | <b>YES</b> No |
| 4. Family history of hearing impairment?<br>Comments:          | <b>YES</b> No | 8. Other concerns?<br>Comments:          | <b>YES</b> 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						