Edinburgh Postnatal Depression Scale[1] (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
- ☐ No, not very often
- ☐ No, not at all

This would mean: "I have felt happy most of the time" during the past week. Please complete the other questions in the same way.

In the past 7 days:

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 copied 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

Administered/Reviewed by _____ Date _____

[1]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.

[2]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

ASQ-3 Ages & Stages Questionnaires®

1 month 0 days through 2 months 30 days

2 Month Questionnaire

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: _____

Relationship to baby:
◯ Parent ◯ Guardian ◯ Teacher ◯ Child care provider
◯ Grandparent or other relative ◯ Foster parent ◯ Other: _____

Street address: _____

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: _____

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ASQ-3

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:

_____

_____

_____

_____

COMMUNICATION

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

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?	○	○	○	___
2. When your baby is on her tummy, does she turn her head to the side?	○	○	○	___
3. When your baby is on his tummy, does he hold his head up longer than a few seconds?	○	○	○	___
4. When your baby is on her back, does she kick her legs?	○	○	○	___
5. While your baby is on his back, does he move his head from side to side?	○	○	○	___
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?	○	○	○	___

GROSS MOTOR TOTAL ___

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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."*)	○	○	○	___
2. Does your baby grasp your finger if you touch the palm of her hand? 	○	○	○	___
3. When you put a toy in his hand, does your baby hold it in his hand briefly? 	○	○	○	___
4. Does your baby touch her face with her hands?	○	○	○	___
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)? 	○	○	○	___ *
6. Does your baby grab or scratch at her clothes?	○	○	○	___

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?	○	○	○	___
2. When you move around, does your baby follow you with his eyes?	○	○	○	___
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?	○	○	○	___
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?	○	○	○	___
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?	○	○	○	___
6. When you dangle a toy above your baby while he is lying on his back, does he wave his arms toward the toy? 	○	○	○	___

PROBLEM SOLVING TOTAL ___

PERSONAL-SOCIAL

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

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

5. Do you have concerns about your baby's behavior (for example, eating, sleeping)? If yes, explain: ○ YES ○ NO

6. Does anything about your baby worry you? If yes, explain: ○ YES ○ NO

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		●	●	●	●	●	○	○	○	○	○	○	○	○
Gross Motor	41.84		●	●	●	●	●	●	●	●	●	○	○	○	○
Fine Motor	30.16		●	●	●	●	●	●	○	○	○	○	○	○	○
Problem Solving	24.62		●	●	●	●	●	○	○	○	○	○	○	○	○
Personal-Social	33.71		●	●	●	●	●	●	●	○	○	○	○	○	○

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

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

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						

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