

EDINBURGH POSTNATAL DEPRESSION SCALE

Parent's Name: _____ (print surname) _____ (print first name)
Baby's DOB: _____ vv / mm / dd _____ Date of Completion: _____ vv / mm / dd

As you have recently had a baby, we would like to know how you are feeling now. Please mark an "X" in the box that comes closest to how you have felt *in the previous 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 coped 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

Please share this scale with your health care provider.