HOLYOKE PEDIATRIC ASSOCIATES, LLP

Today's Date: _____

Name of Baby: _____ Baby's Date of Birth: _____

Parents' Names: _____

Congratulations on your new baby!! We are excited to be a part of this important time in your life! Our job is to make sure your baby is getting the best healthcare possible and to help you adjust to the changes the new baby brings to your life.

Parents may experience a variety of feelings and emotional adjustments throughout the first year of their child's life. Since your emotional well being can have a significant impact on your health as well as the health and wellness of your family, the American Academy of Pediatrics recommends that parents complete a health screening process at pediatric visits.

Therefore, at several of the visits during the first year of your child's life, you will be asked to complete a brief questionnaire about how you are adjusting to your child's first year of life. Your answers should reflect your feelings over the past 7 days.

Since we will be conducting the screening throughout the first year of your child's life, we would like to include the score in your child's medical record, but we need your authorization to do so. Both the score and the answers to the screening questions, with your permission, will be retained in the electronic medical record of your child. This information is protected by Holyoke Pediatric Associates' privacy standards. Unlike a medical record in your own name, your child's medical record may be accessed by either parent, legal guardian, your child's insurance carrier, or your child at the age of eighteen. If you do not agree to have the results retained in your child's medical record, you can still participate in the screening. However, there will be no record of your screening results.

I agree to have the results of the screening retained in my child's medical record. I have read this authorization; have had an opportunity to ask questions and have had my questions answered.

_____	_____	_____
Signature of Parent(s)	Date (expires in 1 year)	Witness

We request your permission to share any concerns about the screening results with your healthcare providers. Please indicate their information below:

_____	_____
OBGYN/Midwife	Phone Number
_____	_____
Primary Care Provider	Phone Number
_____	_____
Therapist/Psychiatrist	Phone Number

Edinburgh Postnatal Depression Scale (EPDS)

Date: _____ Clinic Name/Number: _____

Your Age: _____ Weeks of Pregnancy/Age of Baby: _____

Since you are either pregnant or have recently had a baby, we want to know how you feel. Please place a **CHECK MARK** (✔) on the blank by the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**—*not just how you feel today.* Complete all 10 items and find your score by adding each number that appears in parentheses (#) by your checked answer. This is a screening test; not a medical diagnosis. If something doesn't seem right, *call your health care provider regardless of your score.*

Below is an example already completed.

I have felt happy:
Yes, all of the time ____ (0)
Yes, most of the time ✔ (1)
No, not very often ____ (2)
No, not at all ____ (3)

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

1. I have been able to laugh and see the funny side of things:
   As much as I always could ____ (0)
   Not quite so much now ____ (1)
   Definitely not so much now ____ (2)
   Not at all ____ (3)

2. I have looked forward with enjoyment to things:
   As much as I ever did ____ (0)
   Rather less than I used to ____ (1)
   Definitely less than I used to ____ (2)
   Hardly at all ____ (3)

3. I have blamed myself unnecessarily when things went wrong:
   Yes, most of the time ____ (3)
   Yes, some of the time ____ (2)
   Not very often ____ (1)
   No, never ____ (0)

4. I have been anxious or worried for no good reason:
   No, not at all ____ (0)
   Hardly ever ____ (1)
   Yes, sometimes ____ (2)
   Yes, very often ____ (3)

5. I have felt scared or panicky for no good reason:
   Yes, quite a lot ____ (3)
   Yes, sometimes ____ (2)
   No, not much ____ (1)
   No, not at all ____ (0)

6. Things have been getting to me:
   Yes, most of the time I haven't been able to cope at all ____ (3)
   Yes, sometimes I haven't been coping as well as usual ____ (2)
   No, most of the time I have coped quite well ____ (1)
   No, I have been coping as well as ever ____ (0)

7. I have been so unhappy that I have had difficulty sleeping:
   Yes, most of the time ____ (3)
   Yes, sometimes ____ (2)
   No, not very often ____ (1)
   No, not at all ____ (0)

8. I have felt sad or miserable:
   Yes, most of the time ____ (3)
   Yes, quite often ____ (2)
   Not very often ____ (1)
   No, not at all ____ (0)

9. I have been so unhappy that I have been crying:
   Yes, most of the time ____ (3)
   Yes, quite often ____ (2)
   Only occasionally ____ (1)
   No, never ____ (0)

10. The thought of harming myself has occurred to me:*
    Yes, quite often ____ (3)
    Sometimes ____ (2)
    Hardly ever ____ (1)
    Never ____ (0)

Edinburgh Postnatal Depression Scale (EPDS). Adapted from the *British Journal of Psychiatry*, June, 1987, vol. 150 by J.L. Cox, J.M. Holden, R. Segovsky.