



EDINBURGH POSTNATAL SCORING SHEET  
EDINBURGH POSTNATAL DEPRESSION SCALE  
Professional Use Only

Parent's Name: \_\_\_\_\_ (print surname) \_\_\_\_\_ (print first name)  
Baby's DOB: \_\_\_\_\_ yy / mm / dd \_\_\_\_\_ Date of Completion: \_\_\_\_\_ yy / 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:  
 0 As much as I always could  
 1 Not quite so much now  
 2 Definitely not so much now  
 3 Not at all
2. I have looked forward with enjoyment to things:  
 0 As much as I ever did  
 1 Rather less than I used to  
 2 Definitely less than I used to  
 3 Hardly at all
3. I have blamed myself unnecessarily when things went wrong:  
 3 Yes, most of the time  
 2 Yes, some of the time  
 1 Not very often  
 0 No, never
4. I have been anxious or worried for no good reason:  
 0 No, not at all  
 1 Hardly ever  
 2 Yes, sometimes  
 3 Yes, very often
5. I have felt scared or panicky for no very good reason:  
 3 Yes, quite a lot  
 2 Yes, sometimes  
 1 No, not much  
 0 No, not at all
6. Things have been getting on top of me:  
 3 Yes, most of the time I haven't been able to cope at all  
 2 Yes, sometimes I haven't been coping as well as usual  
 1 No, most of the time I have coped quite well  
 0 No, I have been coping as well as ever
7. I have been so unhappy that I have had difficulty sleeping:  
 3 Yes, most of the time  
 2 Yes, sometimes  
 1 Not very often  
 0 No, not at all
8. I have felt sad or miserable:  
 3 Yes, most of the time  
 2 Yes, quite often  
 1 Not very often  
 0 No, not at all
9. I have been so unhappy that I have been crying:  
 3 Yes, most of the time  
 2 Yes, quite often  
 1 Only occasionally  
 0 No, never
10. The thought of harming myself has occurred to me:  
 3 Yes, quite often  
 2 Sometimes  
 1 Hardly ever  
 0 Never

**Scoring:** Clients with a positive response to item # 10 (regardless of EPDS score) should be assessed A.S.A.P. by their health care provider or local emergency department.

**Total Score out of 30:** \_\_\_\_\_ **Scored by:** \_\_\_\_\_ (print name/designation)

**Sign:** \_\_\_\_\_ (sign) **Date:** \_\_\_\_\_ yy / mm / dd **Time:** \_\_\_\_\_