## EDINBURGH POSTNATAL DEPRESSION SCALE SCORING SHEET

**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 felt worried and anxious for no very 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 very good reason:**

| | |
|---|---|
| Yes, quite a lot | 3 |
| Yes, sometimes | 2 |
| No, not much | 1 |
| No, not at all | 0 |

**6. Things have been getting on top of 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 |
| 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 Scoring Instructions**

This self report scale is a screening tool and not diagnostic of depression.
Please get your clients to complete this at the visit.
Please go through the form and check the details with any answer, where the score is 1 and over.

**Any indication of self harm please refer to the client's GP, Maternal Mental Health Team or Community Mental Health Centre Crisis Team.**

**Scoring:**

Scores: 0 to 3
No changes = 0, to most changes = 3

Example: 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 |

Add up the total scores for all questions i.e. total out of 30.
A score of 13 and over is significant and may be indicative of depression.
High scores over a two week period indicates a need for the GP or Mental Health Service to review.