
# 4 months

Please complete these forms before your visit today.

Thank you!

# Edinburgh Postnatal Depression Scale[1] (EPDS)

**PLACE PATIENT LABEL HERE**

Mother's OB or Doctor's Name _____

Phone: _____

As you have recently had a baby, we would like to know how you are feeling.

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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 — This would mean: "I have felt happy most of the time" during the past week.
- ☐ No, not very often — Please complete the other questions in the same way.
- ☐ No, not at all

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 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

**Score:** _____

Office use only ☐ Declined ☐ Home Visiting ☐ Counseling

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.

# Staying Healthy Assessment

**0-6 Months**

| Child's Name (first & last) | Date of Birth | ☐ Female ☐ Male | Today's Date | In Child/Day Care ☐ Yes ☐ No |
|---|---|---|---|---|
| Person Completing Form | ☐ Parent ☐ Relative ☐ Friend ☐Guardian ☐ Other (specify) | | | Need Help with Form ☐ Yes ☐ No |

*Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.*

Need Interpreter? ☐ Yes ☐ No

| | | | | | ***Clinic Use Only:*** |
|---|---|---|---|---|---|
| 1 | Do you breastfeed your baby? | Yes | No | Skip | *Nutrition* |
| 2 | Are you concerned about your baby's weight? | No | Yes | Skip | *Physical Activity* |
| 3 | Does your baby watch any TV? | No | Yes | Skip | |
| 4 | Does your home have a working smoke detector? | Yes | No | Skip | *Safety* |
| 5 | Have you turned your water temperature down to low-warm (less than 120 degrees)? | Yes | No | Skip | |
| 6 | If your home has more than one floor, do you have safety guards on the windows and gates for the stairs? | Yes | No | Skip | |
| 7 | Does your home have cleaning supplies, medicines, and matches locked away? | Yes | No | Skip | |
| 8 | Does your home have the phone number of the Poison Control Center (800-222-1222) posted by your phone? | Yes | No | Skip | |
| 9 | Do you always put your baby to sleep on his/her back? | Yes | No | Skip | |
| 10 | Do you always stay with your baby when she/he is in the bathtub? | Yes | No | Skip | |
| 11 | Do you always place your baby in a rear-facing car seat in the back seat? | Yes | No | Skip | |
| 12 | Is the car seat you use the correct one for the age and size of your baby? | Yes | No | Skip | |
| 13 | Does your baby spend time in a home where a gun is kept? | No | Yes | Skip | |
| 14 | Do you give your baby a bottle with anything except formula, breast milk, or water? | No | Yes | Skip | *Dental Health* |
| 15 | Does your baby spend time with anyone who smokes? | No | Yes | Skip | *Drug, Alcohol & Tobacco Exposure* |

| | | | | | |
|---|---|---|---|---|---|
| 16 | Does your child have any family members who have or have had a problem with alcohol or other drugs? | No | Yes | Skip | |
| 17 | Does your child have any family members who suffer from depression, anxiety, PTSD or other mental health conditions? | No | Yes | Skip | *Home Environment* |
| 18 | (For parents) Does a partner, or anyone at home, hurt, hit or threaten you? | No | Yes | Skip | |
| 19 | Has your child ever been away from either parent due to parental illness, separation, foster care, parental incarceration or other reasons? | No | Yes | Skip | |
| 20 | Has anything really scary or upsetting happened to your child or anyone in your family? | No | Yes | Skip | |
| 21 | In the last year, have you been worried that your food would run out before you were able to get more? | No | Yes | Skip | *Other Questions* |
| 22 | In the last year, have you been worried that you would need to move out of a place you were staying due to inability to afford the rent, or for other reasons? | No | Yes | Skip | |
| 23 | Do you have any other questions or concerns about your baby's health, development, or behavior? | No | Yes | Skip | |

*If yes, please describe:*

| **Clinic Use Only** | Counseled | Referred | Anticipatory Guidance | Follow-up Ordered | Comments: |
|---|---|---|---|---|---|
| ☐ Nutrition | ☐ | ☐ | ☐ | ☐ | |
| ☐ Physical Activity | ☐ | ☐ | ☐ | ☐ | |
| ☐ Safety | ☐ | ☐ | ☐ | ☐ | |
| ☐ Dental Health | ☐ | ☐ | ☐ | ☐ | |
| ☐ Drug, Alcohol & Tobacco Exposure | ☐ | ☐ | ☐ | ☐ | ☐ **Patient Declined the SHA** |
| ☐ Home Environment | ☐ | ☐ | ☐ | ☐ | |

| PCP's Signature: | Print Name: | Date: |
|---|---|---|
| | | |

GARDNER
Packard Children's Health Center

## Family Needs Screening[1,2]

Our goal at Gardner Packard Children's Health Center is to provide the best possible care for your child and family. We would like to make sure you know resources available to you for your family's needs. Please answer both questions and give to your child's doctor at the beginning of the visit. Thank You!

1. Which of these would you like help with today? (Check all that apply)

   - ❑ Food
   - ❑ Housing
   - ❑ Living conditions (like mold in your home)
   - ❑ Utilities
   - ❑ Transportation
   - ❑ Tutoring or Homework Help
   - ❑ Childcare or preschool

   - ❑ None of these

2. Which of the concerns above is most important to talk about today?

Adapted from: [1] Centers for Medicare & Medicaid Services (CMS) Accountable Health Communities (AHC) Health Related Social Needs Screening Tool and [2] WE-CARE: Well-child care visit; Evaluation; Community resources; Advocacy; Referral; Education. Modified on 6/12/2018.