Name: _____ DOB: _____ Date: _____

2 Months (1 month 0 days through 2 months 30 days)

COMMUNICATION

	YES	SOMETIMES	NOT YET	
1. Does your baby sometimes make throaty or gurgling sounds?	○	○	○	___
2. Does your baby make cooing sounds such as "ooo," "gah," and "aah"?	○	○	○	___
3. When you speak to your baby, does she make sounds back to you?	○	○	○	___
4. Does your baby smile when you talk to him?	○	○	○	___
5. Does your baby chuckle softly?	○	○	○	___
6. After you have been out of sight, does your baby smile or get excited when she sees you?	○	○	○	___

COMMUNICATION TOTAL ___

GROSS MOTOR

	YES	SOMETIMES	NOT YET	
1. While your baby is on his back, does he wave his arms and legs, wiggle, and squirm?	○	○	○	___
2. When your baby is on her tummy, does she turn her head to the side?	○	○	○	___
3. When your baby is on his tummy, does he hold his head up longer than a few seconds?	○	○	○	___
4. When your baby is on her back, does she kick her legs?	○	○	○	___
5. While your baby is on his back, does he move his head from side to side?	○	○	○	___
6. After holding her head up while on her tummy, does your baby lay her head back down on the floor, rather than let it drop or fall forward?	○	○	○	___

GROSS MOTOR TOTAL ___

FINE MOTOR

	YES	SOMETIMES	NOT YET	
1. Is your baby's hand usually tightly closed when he is awake? (*If your baby used to do this but no longer does, mark "yes."*)	○	○	○	___
2. Does your baby grasp your finger if you touch the palm of her hand? 	○	○	○	___
3. When you put a toy in his hand, does your baby hold it in his hand briefly? 	○	○	○	___
4. Does your baby touch her face with her hands?	○	○	○	___
5. Does your baby hold his hands open or partly open when he is awake (rather than in fists, as they were when he was a newborn)? 	○	○	○	___ *
6. Does your baby grab or scratch at her clothes?	○	○	○	___

FINE MOTOR TOTAL ___

**If Fine Motor item 5 is marked "yes," mark Fine Motor item 1 as "yes."*

PROBLEM SOLVING

	YES	SOMETIMES	NOT YET	
1. Does your baby look at objects that are 8–10 inches away?	○	○	○	___
2. When you move around, does your baby follow you with his eyes?	○	○	○	___
3. When you move a toy slowly from side to side in front of your baby's face (about 10 inches away), does your baby follow the toy with her eyes, sometimes turning her head?	○	○	○	___
4. When you move a small toy up and down slowly in front of your baby's face (about 10 inches away), does your baby follow the toy with his eyes?	○	○	○	___
5. When you hold your baby in a sitting position, does she look at a toy (about the size of a cup or rattle) that you place on the table or floor in front of her?	○	○	○	___
6. When you dangle a toy above your baby while he is lying on his back, does he wave his arms toward the toy? 	○	○	○	___

PROBLEM SOLVING TOTAL ___

PERSONAL-SOCIAL

	YES	SOMETIMES	NOT YET	
1. Does your baby sometimes try to suck, even when she's not feeding?	○	○	○	___
2. Does your baby cry when he is hungry, wet, tired, or wants to be held?	○	○	○	___
3. Does your baby smile at you?	○	○	○	___
4. When you smile at your baby, does she smile back?	○	○	○	___
5. Does your baby watch his hands? 	○	○	○	___
6. When your baby sees the breast or bottle, does she seem to know she is about to be fed?	○	○	○	___

PERSONAL-SOCIAL TOTAL ___

SCORE AND TRANSFER TOTALS TO CHART BELOW: See *ASQ-3 User's Guide* for details, including how to adjust scores if item responses are missing. Score each item (YES = 10, SOMETIMES = 5, NOT YET = 0). Add item scores, and record each area total. In the chart below, transfer the total scores, and fill in the circles corresponding with the total scores.

Area	Cutoff	Total Score	0	5	10	15	20	25	30	35	40	45	50	55	60
Communication	22.77		●	●	●	●	●	○	○	○	○	○	○	○	○
Gross Motor	41.84		●	●	●	●	●	●	●	●	●	○	○	○	○
Fine Motor	30.16		●	●	●	●	●	●	●	○	○	○	○	○	○
Problem Solving	24.62		●	●	●	●	●	○	○	○	○	○	○	○	○
Personal-Social	33.71		●	●	●	●	●	●	●	○	○	○	○	○	○

Edinburgh Postnatal Depression Scale (EPDS)

Patient Name: _____ **Patient DOB:** _____

Mother's name: _____ **Date:** _____

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)

TOTAL YOUR SCORE HERE ▶

Thank you for completing this survey. Your doctor will score this survey and discuss the results with you.

Verbal consent to contact above mentioned MD witnessed by:

_____

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.

Escala Edinburgh para la Depresión Postnatal (Spanish Version)

Nombre de Paciente: _____ **Fecha de nacimiento:** _____

Nombre de mama: _____ **Fecha:** _____

Como usted está embarazada o hace poco que tuvo un bebé, nos gustaría saber como se siente actualmente. Por favor MARQUE (√) la respuesta que más se acerca a como se ha sentido durante LOS ÚLTIMOS 7 DÍAS y no sólo como se ha sentido hoy.

A continuación se muestra un ejemplo completado:

Me he sentido feliz:
Sí, todo el tiempo ___ 0
Sí, la mayor parte del tiempo ✔ 1
No, no muy a menudo ___ 2
No, en absoluto ___ 3

Esto significa: "Me he sentido feliz la mayor parte del tiempo" durante la última semana. Por favor complete las otras preguntas de la misma manera.

1. He podido reír y ver el lado bueno de las cosas:
   Tanto como siempre he podido hacerlo ___ 0
   No tanto ahora ___ 1
   Sin duda, mucho menos ahora ___ 2
   No, en absoluto ___ 3

2. He mirado al futuro con placer para hacer cosas:
   Tanto como siempre ___ 0
   Algo menos de lo que solía hacerlo ___ 1
   Definitivamente menos de lo que solía hacerlo ___ 2
   Prácticamente nunca ___ 3

3. Me he culpado sin necesidad cuando las cosas marchaban mal:
   Sí, casi siempre ___ 3
   Sí, algunas veces ___ 2
   No muy a menudo ___ 1
   No, nunca ___ 0

4. He estado ansiosa y preocupada sin motivo alguno:
   No, en absoluto ___ 0
   Casi nada ___ 1
   Sí, a veces ___ 2
   Sí, muy a menudo ___ 3

5. He sentido miedo o pánico sin motivo alguno:
   Sí, bastante ___ 3
   Sí, a veces ___ 2
   No, no mucho ___ 1
   No, en absoluto ___ 0

6. Las cosas me oprimen o agobian:
   Sí, la mayor parte del tiempo no he podido sobrellevarlas ___ 3
   Sí, a veces no he podido sobrellevarlas de la manera ___ 2
   No, la mayoría de las veces he podido sobrellevarlas bastante bien ___ 1
   No, he podido sobrellevarlas tan bien como lo hecho siempre ___ 0

7. Me he sentido tan infeliz, que he tenido dificultad para dormir:
   Sí, casi siempre ___ 3
   Sí, a veces ___ 2
   No muy a menudo ___ 1
   No, en absoluto ___ 0

8. Me he sentido triste y desgraciada:
   Sí, casi siempre ___ 3
   Sí, bastante a menudo ___ 2
   No muy a menudo ___ 1
   No, en absoluto ___ 0

9. Me he sentido tan infeliz que he estado llorando:
   Sí, casi siempre ___ 3
   Sí, bastante a menudo ___ 2
   Ocasionalmente ___ 1
   No, nunca ___ 0

10. He pensado en hacerme daño:
    Sí, bastante a menudo ___ 3
    A veces ___ 2
    Casi nunca ___ 1
    No, nunca ___ 0

Total Score: _____

Consentimiento verbal para contacto arriba mencionado MD presenciada por:

_____

Edinburgh Postnatal Depression Scale (EPDS). Texto adaptado del *British Journal of Psychiatry*, Junio, 1987, vol. 150 por J.L. Cox, J.M. Holden, R. Segovsky.