Perinatal Services BC
An agency of the Provincial Health Services Authority

Edinburgh Perinatal/Postnatal Depression Scale (EPDS)

For use between **28–32 weeks** in **all** pregnancies

Name: _____ Date: _____ Gestation in Weeks: _____

As you are having a baby, we would like to know how you are feeling. Please mark "X" in the box next to the answer which comes closest to how you have felt in the past 7 days–not just how you feel today.

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
   - ☐ 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

Talk about your answers to the above questions with your health care provider.

Translations for care-provider use available on PSBC website: perinatalservicesbc.ca.

Edinburgh Perinatal/Postnatal Depression Scale (EPDS)

SCORING GUIDE

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
   - 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

A score of 1–3 to item 10 indicating a risk of self-harm, requires immediate mental health assessment and intervention as appropriate.

Scoring of 11–13 range, monitor, support, and offer education.

Scoring of 14 or higher, follow up with comprehensive bio-psychosocial diagnostic assessment for depression.

Source: Cox, JL Cox, Holden, JM, Sagovsky, R (1987) Department of Psychiatry, University of Edinburgh

TWEAK SCORING GUIDE

T	**Tolerance:** "How many drinks does it take to make you feel high?" (Or this can be modified to "How many drinks can you hold?") Record number of drinks.	3 or more drinks = 2 points
W	**Worry:** "Have close friends or relatives worried or complained about your drinking in the past year?	Yes = 2 points
E	**Eye-Opener:** "Do you sometimes have a drink in the morning when you first get up?"	Yes = 1 point
A	**Amnesia (Blackout):** Has a friend or family member ever told you about things you said or did while you were drinking that you could not remember?	Yes = 1 point
K (C)	**Cut Down:** "Do you sometimes feel the need to cut down on your drinking?"	Yes = 1 point

A score of 2 or more points indicates a risk of a drinking problem.

Source: Russell, M (1994). New Assessment tools for risk drinking during pregnancy: T-ACE, TWEAK and others. Alcohol Health and Research World.