The Edinburgh Postnatal Depression Scale: Scoring Sheet (English and validated translated versions)

Note: scoring is the same for both the *EPDS* English and *EPDS* validated translated versions

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 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

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Alberta Health Services

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

Administered/Reviewed by:
Date:

Score:

How to Score the EPDS

- Use the *EPDS Scoring Sheet* to score each response. The *EPDS Scoring Sheet* is used for both English and validated translated versions.
- Add the scores from each response to calculate a total score out of 30.
- If the mother answers anything but “never” on Q#10 this indicates possible suicide risk. Use the *Suicide Risk Referral Flowchart* and *User Guide* to determine nursing action(s).
- Retain the mother’s original *EPDS* in the electronic medical record for 11 years as per *AHS Records Retention Schedule*.