MATERNAL DEPRESSION SCREENING

To be filled out by biological mother of baby ___ 1ST newborn visit ___ 2 month visit

BABY'S NAME: ______________________________ **Birthdate** ____________

BIOLOGICAL MOTHER'S NAME ______________________________ **Today's Date** _________

Over the last 2 weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Scoring For Use By Clinical Personnel Only

0 + ___ + ___ + ___

= Total Score: ___

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

___ not difficult at all ___ somewhat difficult ___ very difficult ___ extremely difficult

Is there someone you can turn to and rely on for support when you are feeling stressed, or do you have adequate support? ___ Yes ___ No

I confirm this information is accurate. Mom signature ______________________________ **Date** _________

Based on form developed by Drs. Robert L Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc.
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