Hudson Valley Whole Life Center **Postpartum Re-evaluation**

Name: _____ **Date:** _____

1. Please list your top 3 initial concerns and circle how they have changed postpartum:

   a. Concern: _____ SAME BETTER WORSE
   b. Concern: _____ SAME BETTER WORSE
   c. Concern: _____ SAME BETTER WORSE

2. If needed, please explain any answers from question 1:

   _____

   _____

3. Tell us about labor and delivery:
   a. Baby born at _____ weeks with _____ delivery (vaginal/cesarean).
   b. Additional details (use back if needed): _____

      _____

4. Tell us about the first 2 hours of baby's life (was baby able to stay with you, NICU?, skin to skin?, breastfeeding experience etc): _____

   _____

5. How are you feeling ***emotionally*** about your birth and postpartum experience so far?

   _____

   _____

6. How are you feeling ***physically*** about your postpartum healing so far?

   _____

   _____

7. Please list and rate your top 3 initial concerns **physically *and* emotionally** as we move forward:
   a. Concern: _____ Scale of 1-10 (10 being the most severe): _____/10
   b. Concern: _____ Scale of 1-10 (10 being the most severe): _____/10
   c. Concern: _____ Scale of 1-10 (10 being the most severe): _____/10

8. If needed, please explain any answers from question 7:

   _____

   _____

9. What postpartum resources can we help you connect with?

   _____

10. Is there anything else the doctors should be aware of? _____

    _____

EDINBURGH POSTNATAL DEPRESSION SCALE (EPDS)

The EPDS was developed for screening postpartum women in outpatient, home visiting settings, or at the 6 –8 week postpartum examination. It has been utilized among numerous populations including U.S. women and Spanish speaking women in other countries. The EPDS consists of 10 questions. The test can usually be completed in less than 5 minutes. Responses are scored 0, 1, 2, or 3 according to increased severity of the symptom. Items marked with an asterisk (*) are reverse scored (i.e., 3, 2, 1, and 0). The total score is determined by adding together the scores for each of the 10 items. Validation studies have utilized various threshold scores in determining which women were positive and in need of referral. Cut-off scores ranged from 9 to 13 points. Therefore, to err on safety's side, a woman scoring 9 or more points or indicating any suicidal ideation – that is she scores 1 or higher on question #10 – should be referred immediately for follow-up. Even if a woman scores less than 9, if the clinician feels the client is suffering from depression, an appropriate referral should be made. The EPDS is only a screening tool. It does not diagnose depression – that is done by appropriately licensed health care personnel.

Instructions for Users

1. The mother is asked to underline 1 of 4 possible responses that comes the closest to how she has been feeling the previous 7 days.
2. All 10 items must be completed.
3. Care should be taken to avoid the possibility of the mother discussing her answers with others.
4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.

Name:
Date:
Address:
Baby's Age:

As you have recently had a baby, we would like to know how you are feeling. Please UNDERLINE the answer which 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
No, not very often
No, not at all

This would mean: "I have felt happy most of the time" during the past week. Please complete the other questions in the same way.

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, 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

EDINBURGH POSTNATAL DEPRESSION SCALE (EPDS)
J. L. Cox, J.M. Holden, R. Sagovsky
From: *British Journal of Psychiatry* (1987), 150, 782-786.

HUDSON VALLEY
WHOLE LIFE CENTER

Patient Name:_____ **Patient Date of Birth:**_____/_____/_____

Complaint #___-_____

When did you first notice this condition?

Did it begin: ☐Immediate or ☐Gradually? Briefly describe

What is the exact location of your symptoms:

Do your symptoms spread? ☐No ☐Yes Where?

How often do you experience these symptoms? ☐Constant (100% of the day) ☐Frequent ☐Often (50%) ☐Seldom (25%) ☐Rarely (less than 25%)

Is this condition progressively: ☐Worsening ☐Improving or ☐Unchanged

What is the intensity of your symptoms? ☐Severe ☐Moderate ☐Mild

Rate your symptoms on a scale of 1-10 considering 1 (minimal) and 10 (severe/excruciating pain)
☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Is your pain ☐Deep or ☐Superficial

Please indicate the character of your pain: ☐Dull ☐Sharp ☐Burning ☐Aching ☐Knife-like ☐Throbbing

Are you experiencing any of the following associated symptoms? ☐Pins/Needles ☐Tingling ☐Numbness ☐Twitching If yes, please describe:

Please indicate what activities Provoke(P) or Aggravate(A) your condition:
☐Sitting__min. ☐Standing ☐Walking ☐Lying ☐Pushing ☐Lifting___lbs. ☐Gripping ☐Hot/Cold ☐Coughing/sneezing ☐Bowel Movements ☐Mental activities ☐Bright lights ☐Other_____
☐Other_____ ☐Other_____ ☐Other_____

Please indicate what helps to alleviate the pain:
☐Lying ☐Sitting ☐Walking ☐Standing ☐Rest ☐Heat/Cold ☐Medications_____
☐_____ ☐_____ ☐_____

Please list what doctors you have seen for this condition. (Please include diagnoses, treatment received, and any changes in your condition.

Please include any other relevant history in regards to this complaint.