Edinburgh Postnatal Depression Scale[1] (EPDS)

Mother's Name:_____ Baby's Name: _____

Acct #: _____ Baby's DOB: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that 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 (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)

*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 _____

Total Score: _____

Date of Service: _____ Acct #: _____
Patient Name: _____ DOB: _____

Medical Screening Questionnaire

Does your child have a sibling or playmate that has had lead poisoning?	YES	NO	UNSURE
Does your child live in or regularly visit a house or childcare facility built before 1978 that has been renovated in the last 6 months? Do you live in or visit a home or facility built before 1950?	YES	NO	UNSURE
Does your child chew on or eat non-food items like paint chips or dirt?	YES	NO	UNSURE
Was your child born in a country or traveled for longer than a week to a country at high risk for tuberculosis? Is there a family member or close contact with TB or had a positive TB test?	YES	NO	UNSURE
Is your child infected with HIV or have any conditions that lower the immune system?	YES	NO	UNSURE
Has your child been exposed to anyone who is in jail, has HIV, is homeless, or uses illegal drugs?	YES	NO	UNSURE
Has a doctor ever ordered a test for your child's heart or does your child see a Cardiologist?	YES	NO	UNSURE
Has your child ever had discomfort, pain, or pressure in his chest during exercise?	YES	NO	UNSURE
Has your child ever had extreme shortness of breath, or extreme fatigue during exercise (different from other children)?	YES	NO	UNSURE
Has your child fainted or passed out, or had a seizure DURING or AFTER exercise, emotion, or startle?	YES	NO	UNSURE
Are there any family members who had a sudden, unexpected, unexplained death before age 50? (Including SIDS, car accident, drowning, others) or near drowning? If yes, what? _____	YES	NO	UNSURE
Does your child have a parent or sibling with the following conditions? Hypertrophic cardiomyopathy, long or short QT syndrome, Marfans or Loeys-Dietz, Arrhythmogenic right ventricular cardiomyopathy, Brugada syndrome, Catecholaminergic polymorphic ventricular tachycardia	YES	NO	UNSURE
Anyone younger than 50 years old with a pacemaker or implantable defibrillator?	YES	NO	UNSURE
Do you have any concerns about how your child sees?	YES	NO	UNSURE
Do you have any concerns about how your child hears?	YES	NO	UNSURE
Do you have any concerns about your child's speech?	YES	NO	UNSURE
Does anyone in your household smoke?	YES	NO	UNSURE
Do you have city or well water?	CITY		WELL
Does your child have a dentist? If yes, have they been seen in the last 6 months?	YES	NO	

For Patients 11 years and older

Do you wear a seat belt all the time? YES NO
Are you or have you ever been sexually active? YES NO

Do you or have you ever ridden in a car driven by someone who was using drugs or alcohol? YES NO
Do you or have you ever smoked cigarettes (regular or electronic)/VAPE/JUUL? YES NO
Do you or have you ever used any kind of drugs including synthetic marijuana (spice, K2) or alcohol? YES NO
Have you ever gotten into trouble while using drugs or alcohol? YES NO
Do you use anything else to get high (like other illegal drugs, pills, prescription or over-the-counter medications, and things that you sniff, huff, vape, or inject)? YES NO

PLEASE ANSWER THE QUESTIONS ON THE BACK IF YOU ARE 11 YEARS OR OLDER.

Date: _____ Acct #: _____

Patient Name(s): _____ DOB: _____

PEDIATRIC ASSOCIATES

The services listed below may be provided by Pediatric Associates and may not be covered by your insurance carrier. I understand that **I will be responsible for the services rendered**. This includes but is not limited to Hearing and Vision Screenings, Fluoride Varnish, Ages & Stages, and Vanderbilt forms.

We are unable to verify coverage on all patients: therefore, it is your responsibility to check with your insurance carrier to determine if the services are covered.

IMMUNIZATIONS:

1. _____ I have NO insurance to pay for immunizations (includes: Medi-share, Liberty Aliera, Unity, OneShare, Solidarity, Christian Health Ministries, and Samaritan)
2. _____ I have Medicaid/Peachcare/Amerigroup/Peachstate/Caresource
3. _____ My insurance pays for immunizations
4. _____ My insurance does NOT cover preventative services
5. _____ I request a copy of an updated 3231 Immunization Form

* You will be provided with an information packet regarding immunizations administered today. *

Please be aware that we are now required to do hearing and vision screens at the ages of 3, 4, 5, 6, 8, 10, 15 and 18yrs. **Your insurance carrier may or may not cover the hearing and/or vision screen. Please be aware that you will be responsible for the $20.00 charge for the hearing screen and $20.00 for the vision screen if it is not a covered service.**

There will be a $10.00 charge for Fluoride Varnish if it is not a covered service. This will be performed at 9mos, 15mos, 24mos, 30mos, and 36mos.

I hereby give consent for immunizations to be administered to my child today and/or have the hearing and/or vision screening and/or Fluoride Varnish completed.

_____ I decline to have the Hearing and/or Vision screen completed at this time.

_____ I decline to have the Fluoride Varnish completed at this time.

Parent/Guardian Signature: _____

Witness: _____