Postnatal Screening Tools

The following tools are effective for identifying parents/caregivers at risk of anxiety and depression; they can be used on any parent or guardian. The tools are not meant to override clinical judgement and a careful clinical assessment should be carried out to confirm the diagnosis. Parents/caregivers who are identified as high risk should be referred to community resources as appropriate.
Your healthcare practitioner will review the results with you.

Last Name: **First Name:**

Anxiety Screening: Generalized Anxiety Disorder Scale (GAD-7)

Date: YYYY/MM/DD

The GAD-2 is a screening toold used to assess a client's general anxiety over a two week period.

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several Days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Total Score (max score 21):				
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?	0	1	2	3

Total Score	Interpretation	Total Score	Interpretation
>= 10	Probably diagnosis of GAD; confirm by further evaluation	5	Mild anxiety
10	Moderate anxiety	15	Severe anxiety

Interpretation Source: Spitzer RL, Kroenke K, Williams JB, Lowe B. A brief measure for assessing generalized anxiety disorder: the GAD-7. Arch Intern Med. 2006; 166:1092-1097.

The Patient Health Questionnaire-2 (PHQ-2)

Date: YYYY/MM/DD

The PHQ-2 inquires about the frequency of depressed mood and anhedonia over the past two weeks.

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all sure	Several Days	Over 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
Total Score (max score 27):				
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

Total Score	Interpretation	Total Score	Interpretation
0-4	Minimal Depression	5-9	Mild Depression
10-14	Moderate Depression	15-19	Moderately Severe Depression
20-27	Severe Depression	*Interpretation Source: Kroenke K, Spitzer RL, Williams JB; The PHQ-9: validity of a brief depression severity measure. J Gen Intern Med. 2001 Sep;16(9):606-13.*	