KAISER PERMANENTE®

Mother's Name _____

Mother's Consumer Number _____

Mother's Date of Birth _____

Maternal Mental Health Screening

Over the past 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 family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watch 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
10. Feeling nervous, anxious or on edge	0	1	2	3
11. Not being able to stop or control worrying	0	1	2	3
12. Have your problems interfered with your work, family, or social activities?	0	1	2	3

Please answer these questions about your drinking and substance use in the last 3 months.

13. How often did you have a drink containing alcohol?	**Never** 0	**Monthly or less** 1	**2 to 4 times a month** 2		**2 to 3 times a week** 3	**4 or more times a week** 4
14. How many drinks containing alcohol did you have on a typical day when you were drinking?	**None** 0	**1 or 2 drinks** 0	**3 or 4 drinks** 1	**5 or 6 drinks** 2	**7 or 9 drinks** 3	**10 or more drinks** 4
15. How often did you have 4 or more drinks on one occasion?	**Never** 0	**Less than monthly** 1	**Monthly** 2		**Weekly** 3	**Daily or almost daily** 4
16. How often have you used marijuana?	**Never** 0	**Less than monthly** 1	**Monthly** 2		**Weekly** 3	**Daily or almost daily** 4
17. How often have you used an illegal drug or used a prescription medication for non-medical reasons?	**Never** 0	**Less than monthly** 1	**Monthly** 2		**Weekly** 3	**Daily or almost daily** 4
18. Do you have access to guns?	No	Yes				

Many health problems can be affected by stress in our relationships.
Making the connection can help you take steps toward better health.

19. Are you currently in a relationship where your partner hits, slaps, kicks, or hurts you?	No	Yes	Prefer not to answer
20. Does your partner control where you go or make you feel afraid?	No	Yes	Prefer not to answer
21. Have you ever had a partner who physically hurt or threatened you?	No	Yes	Prefer not to answer

DO NOT SCAN INTO MEDICAL RECORD

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Why we do this Health Screening

Your well-being is very important to the health of your baby and family. During pregnancy and the first year of the baby's life, we ask all women about depression, anxiety, and safety issues. Being a new parent can be exciting, but also sometimes difficult both physically and emotionally. Asking these questions helps us know how you're doing and can help us connect you to care if needed.

Please fill out the back of this form and let us know if you have any questions or concerns. We will enter this information in your medical record if you are a Kaiser Permanente member so your doctor knows how you're doing with the new baby. We're here to make sure you are both healthy and safe.