

MARYLAND STATE MANDATED MATERNAL QUESTIONNAIRE

Mother's Name _____

Patient Name _____ Date _____

1. Over the last 2 weeks, how often have you been bothered by any of the following problems? Read each item carefully, and circle your response.

| | Not at all | Several days | More than half the days | Nearly every day |
|--|---------------|-----------------|----------------------------|---------------------|
| | 0 | 1 | 2 | 3 |
| a. Little interest or pleasure in doing things | | | | |
| b. Feeling down, depressed, or hopeless | | | | |
| c. Trouble falling asleep, staying asleep, or sleeping too much | | | | |
| d. Feeling tired or having little energy | | | | |
| e. Poor appetite or overeating | | | | |
| f. Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down | | | | |
| g. Trouble concentrating on things such as reading the newspaper or watching television | | | | |
| h. Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual | | | | |
| i. Thinking that you would be better off dead or that you want to hurt yourself in some way | | | | |
| Totals | | | | |

2. If you checked off any problem on this questionnaire so far, 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 |
|----------------------|--------------------|----------------|---------------------|
| 0 | 1 | 2 | 3 |
| | | | |