

# Antenatal (Psychosocial) Risk Questionnaire (ANRQ) – Client with postnatal items

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Name: \_\_\_\_\_ Date: \_\_\_\_\_

The questions below are designed to help you and your clinician understand whether you may benefit from some extra support during this time of change. You may find some questions challenging, but please choose the answers that best apply to you. There are no right or wrong answers.

Please complete all questions, unless instructed to SKIP a question. Once you have completed the questions, your clinician will discuss your responses with you. If you have any concerns about any of the questions, please let your clinician know.

Total

**Q1.** Have you ever had a period of 2 weeks or more when you felt particularly worried, miserable or depressed?

No

**If No**, skip to **Q1.c.**

Yes

**If Yes**, please answer **Q1.a.**, **Q1.b.** and **Q1.c.**,

**If Yes**, did this:

**Q1.a.** Seriously interfere with your work or your relationships with friends and family?

Not at all

A little

Somewhat

Quite a lot

Very much



**Q1.b.** Lead you to seek professional help?

Did you see a:

psychiatrist  psychologist/counsellor  GP

Did you take tablets/herbal medicine?  No  Yes

No

Yes

**If yes**, name of professional: \_\_\_\_\_

**If yes**, list medication(s): \_\_\_\_\_

**Q1.c.** Do you have **any other history of mental health problems?** (e.g. eating disorders, psychosis, bipolar, schizophrenia)  No  Yes

**If yes**, list other mental health problems: \_\_\_\_\_

\_\_\_\_\_

**Q2.** Is your relationship with your partner an emotionally supportive one?

Very much

Quite a lot

Somewhat

A little

Not at all

No partner



**Q3.** Have you had any stresses, changes or losses in the last 12 months? (e.g. only: separation, domestic violence, job loss, bereavement etc.)

No

**If No**, skip to **Q4.**

Yes

**If Yes**, please answer **Q3.a.**,

**If yes**, please specify: \_\_\_\_\_

**If Yes:**

**Q3.a.** How distressed were you by these stresses, changes or losses?

Not at all

A little

Somewhat

Quite a lot

Very much



**Q4.** Would you generally consider yourself a worrier?

Not at all

A little

Somewhat

Quite a lot

Very much



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**Q5.** In general, do you become upset if you do not have order in your life? (e.g. regular timetable, tidy house)

Not at all	A little	Somewhat	Quite a lot	Very much	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

**Q6.** Do you feel you will have people you can depend on for support with your baby?

Very much	Quite a lot	Somewhat	A little	Not at all	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

**Now you are having a baby, you may be starting to think about your own childhood and what it was like.**

**Q7.** Were you emotionally abused *when you were growing up*?

No	Yes	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	

**Q8.** Have you **ever** been sexually  or physically  abused?

No	Yes	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	

**Q9.** *When you were growing up*, did you feel your mother was emotionally supportive of you?

Very much	Quite a lot	Somewhat	A little	Not at all	No Mother	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

**If you have already had your baby, please complete the following questions about your experiences.**

Was your experience of giving birth to this baby disappointing or frightening?

Not at all	A little	Somewhat	Quite a lot	Very much
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Has your experience of parenting this baby been a positive one?

Not at all	A little	Somewhat	Quite a lot	Very much
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Overall, has your baby been unsettled or feeding poorly?

Not at all	A little	Somewhat	Quite a lot	Very much
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**And finally...**

Do you feel safe with your current partner?

Not at all	A little	Somewhat	Quite a lot	Very much	No partner
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you think that you (or your partner) may have a problem with drugs or alcohol?

Not at all	A little	Somewhat	Quite a lot	Very much
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any other concerns that you would like to talk about today? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_