

# **Obsessive-Compulsive Disorder Patient Screening Test**

## **PART A**

Please select YES or NO.

**Have you been bothered by unpleasant thoughts or images that repeatedly enter your mind, such as:**

- 1. concerns with contamination (dirt, germs, chemicals, radiation) or acquiring a serious illness such as AIDS?**
- 2. over concern with keeping objects (clothing, groceries, tools) in perfect order or arranged exactly?**
- 3. images of death or other horrible events?**
- 4. personally unacceptable religious or sexual thoughts?**

**Have you worried a lot about terrible things happening, such as:**

- 5. fire, burglary, or flooding the house?**
- 6. accidentally hitting a pedestrian with your car or letting it roll down the hill?**
- 7. spreading an illness (giving someone AIDS)?**
- 8. losing something valuable?**
- 9. harm coming to a loved one because you weren't careful enough?**

**Have you worried about acting on an unwanted and senseless urge or impulse, such as:**

- 10. physically harming a loved one, pushing a stranger in front of a bus, steering your car into oncoming traffic; inappropriate sexual contact; or poisoning dinner**

guests?

**Have you felt driven to perform certain acts over and over again, such as:**

**11. excessive or ritualized washing, cleaning, or grooming?**

**12. checking light switches, water faucets, the stove, door locks, or emergency brake?**

**13. counting; arranging; evening-up behaviors (making sure socks are at same height)?**

**14. collecting useless objects or inspecting the garbage before it is thrown out?**

**15. repeating routine actions (in/out of chair, going through doorway, re-lighting cigarette) a certain number of times or until it feels just right**

**16. need to touch objects or people?**

**17. unnecessary re-reading or re-writing; re-opening envelopes before they are mailed?**

**18. examining your body for signs of illness?**

**19. avoiding colors ("red" means blood), numbers ("13" is unlucky), or names (those that start with "D" signify death) that are associated with dreaded events or unpleasant thoughts?**

**20. needing to "confess" or repeatedly asking for reassurance that you said or did something correctly?**

**SCORING PART A: [TOP](#)**

If you answered YES to 2 or more questions, please continue with Part B.

**PART B**

The following questions refer to the repeated thoughts, images, urges, or behaviors identified in Part A. Consider your experience during the past 30 days when selecting an answer. Select the most appropriate number from 0 to 4.

**1. On average, how much time is occupied by these thoughts or behaviors each day?**

- 0 - None
- 1 - Mild (less than 1 hour)
- 2 - Moderate (1 to 3 hours)
- 3 - Severe (3 to 8 hours)
- 4 - Extreme (more than 8 hours)

**2. How Much distress do they cause you?**

- 0 - None
- 1 - Mild
- 2 - Moderate 3 - Severe
- 4 - Extreme (disabling)

**3. How hard is it for you to control them?**

- 0 - Complete control
- 1 - Much control
- 2 - Moderate control
- 3 - Little control
- 4 - No control

**4. How much do they cause you to avoid doing anything, going any place, or being with anyone?**

- 0 - No avoidance
- 1 - Occasional avoidance
- 2 - Moderate avoidance
- 3 - Frequent and extensive
- 4 - Extreme (housebound)

**5. How much do they interfere with school, work or your social or family life?**

- 0 - None
- 1 - Slight interference
- 2 - Definitely interferes with functioning
- 3 - Much interference
- 4 - Extreme (disabling)

Sum on Part B (Add items 1 to 5): \_\_\_\_\_

**SCORING**

If you answered YES to 2 or more of questions in Part A and scored 5 or more on Part B, you may wish to contact your physician, a mental health professional, or a patient advocacy group (such as, the Obsessive Compulsive Foundation, Inc.) to obtain more information on OCD and its treatment. Remember, a high score on this questionnaire does not necessarily mean you have OCD--only an evaluation by an experienced clinician can make this determination.

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