TRUENORTH PSYCHIATRIC NURSING CORP
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OCD SYMPTOM QUESTIONNAIRE

OCD Symptom & Severity Questionnaire

This TrueNorth screening questionnaire is not the Y-BOCS and is not intended to replace a diagnostic evaluation.

Patient Name: _____ Date: _____

INTRUSIVE THOUGHTS / OBSESSIONS

Have you experienced unwanted, repetitive thoughts, images, urges, or doubts that are difficult to dismiss? ☐ Yes ☐ No

Check any themes that apply:

☐ Contamination / germs ☐ Harm / fear of causing harm ☐ Doubt / need for certainty
☐ Symmetry / exactness ☐ Religious / moral concerns ☐ Unwanted sexual thoughts
☐ Relationship doubts ☐ Health-related fears ☐ Other

Briefly describe the thoughts/urges that bother you most:

COMPULSIONS / REPETITIVE BEHAVIORS

Do you feel driven to perform behaviors or mental rituals to reduce anxiety, uncertainty, or prevent something bad? ☐ Yes ☐ No

Check any that apply:

☐ Washing / cleaning ☐ Checking ☐ Repeating actions
☐ Counting ☐ Ordering / arranging ☐ Mental rituals / reviewing
☐ Seeking reassurance ☐ Avoidance ☐ Other

Briefly describe the behaviors or mental rituals you perform most often:

CURRENT SEVERITY

For each statement, select the response that best describes your experience during the PAST 7 DAYS.

How much of your day is taken up by intrusive thoughts or rituals?

☐ None ☐ Mild ☐ Moderate ☐ Marked ☐ Extreme

How distressing are these symptoms when they occur?

☐ None ☐ Mild ☐ Moderate ☐ Marked ☐ Extreme

How much do these symptoms interfere with work, school, relationships, or daily activities?

☐ None ☐ Mild ☐ Moderate ☐ Marked ☐ Extreme

How difficult is it to disengage from the thoughts or stop/delay the rituals?

☐ None ☐ Mild ☐ Moderate ☐ Marked ☐ Extreme

How much do you avoid people, places, objects, activities, or decisions because of these symptoms?

☐ None ☐ Mild ☐ Moderate ☐ Marked ☐ Extreme

INSIGHT & IMPACT

When symptoms are strongest, how convinced are you that the feared outcome or concern may be true?

☐ I usually recognize the fear may be excessive ☐ I am unsure ☐ It feels very likely or completely true

Approximately when did these symptoms begin? _____ Have they worsened recently? ☐ Yes ☐ No