

Florida Obsessive Compulsive Inventory (FOCI)



PART A

Please check YES or NO for the following questions, based on your experience in the **past month**:

Have you been bothered by unpleasant thoughts or images that repeatedly enter your mind such as:		
1. Concerns about contamination (dirt, germs, chemicals, radiation) or acquiring a serious illness such as AIDS?	<input type="radio"/> Yes	<input type="radio"/> No
2. Over-concern with keeping objects (clothing, tools, etc.) in perfect order or arranged exactly?	<input type="radio"/> Yes	<input type="radio"/> No
3. Images of death or other horrible events?	<input type="radio"/> Yes	<input type="radio"/> No
4. Personally unacceptable religious or sexual thoughts?	<input type="radio"/> Yes	<input type="radio"/> No
Have you worried a lot about terrible things happening, such as:		
5. Fire, burglary, or flooding of your house?	<input type="radio"/> Yes	<input type="radio"/> No
6. Accidentally hitting a pedestrian with your car or letting it roll down a hill?		
7. Spreading an illness (giving someone AIDS)?	<input type="radio"/> Yes	<input type="radio"/> No
8. Losing something valuable?	<input type="radio"/> Yes	<input type="radio"/> No
9. Harm coming to a loved one because you weren't careful enough?	<input type="radio"/> Yes	<input type="radio"/> No
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?	<input type="radio"/> Yes	<input type="radio"/> No
Have you felt driven to perform certain acts over and over again, such as:		
11. Excessive or ritualized washing, cleaning, or grooming?	<input type="radio"/> Yes	<input type="radio"/> No
12. Checking light switches, water faucets, the stove, door locks, or the emergency	<input type="radio"/> Yes	<input type="radio"/> No

brake?

13. Counting, arranging, evening-up behaviors (making sure socks are at the same height)? Yes No

14. Collecting useless objects or inspecting the garbage before it is thrown out? Yes No

15. Repeating routine actions (in/out of chair, going through doorways, relighting cigarettes) a certain number of times until it feels **just right**? Yes No

16. Needing to touch objects or people? Yes No

17. Unnecessary rereading or rewriting; opening envelopes before they are mailed? Yes No

18. Examining your body for signs of illness? Yes No

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? Yes No

20. Needing to “confess” or repeatedly asking for reassurance that you said or did something correctly? Yes No

If you answered YES to one or more of these 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. Check the most appropriate number from 0 to 4.

<p>1. On average, how much <i>time</i> is occupied by these thoughts or behaviors each day</p> <ul style="list-style-type: none"> ● None ● Mild (less than 1 hour) ● Moderate (1-3 hours) ● Severe (3 to 8 hours) ● Extreme (more than 8 hours) 	<p>2. How much <i>distress</i> do they cause you?</p> <ul style="list-style-type: none"> ● None ● Mild ● Moderate ● Severe ● Extreme (disabling)
<p>3. How hard is it for you to <i>control</i> them?</p> <ul style="list-style-type: none"> ● Complete Control ● Much Control ● Moderate Control ● Little Control ● No control 	<p>4. How much do they cause you to <i>avoid</i> doing anything, going anyplace or being with anyone</p> <ul style="list-style-type: none"> ● No avoidance ● Occasional avoidance ● Moderate Avoidance ● Frequent and extensive avoidance ● Extreme Avoidance (housebound)
<p>5. How much do they <i>interfere</i> with school, work or your social or family life?</p> <ul style="list-style-type: none"> ● None ● Slight Interference ● Definitely interferes with functioning ● Much interference ● Extreme Interference (disabling) 	

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