SCREENING TOOLS

Florida Obsessive Compulsive Inventory (MDQ)

The twenty questions below are a consolidated symptom checklist generated from the YBOCS (Yale Brown Obsessive Compulsive Scale). These can be used by the patient to better understand which of their thoughts or behaviors may be contributing to their behavior, and they can be used in therapy to target particular symptoms.

PART A Instructions: Please check YES or NO for the following questions, based on your experience in the past MONTH:

Has there ever been a period of time in your life when you were not your usual self and…		
1. Concerns about contamination (dirt, germs, chemicals, radiation) or acquiring a serious illness such as AIDS?	O Yes	O No
2. Over-concern with keeping objects (clothing, tools, etc.) in perfect order or arranged exactly?	O Yes	O No
3. Images of death or other horrible events?	O Yes	O No
4. Personally unacceptable religious or sexual thoughts?	O Yes	O No
Have you worried a lot about terrible things happening, such as…		
5. Fire, burglary, or flooding of your house?Concerns about contamination (dirt, germs, chemicals, radiation) or acquiring a serious illness such as AIDS?	O Yes	O No
6. Spreading an illness (giving someone AIDS)?	O Yes	O No
7. Harm coming to a loved one because you weren’t careful enough?	O Yes	O No
8. Personally unacceptable religious or sexual thoughts?	O Yes	O No
Have you worried about acting on an Unwanted and senseless urge or impulse, such as:		
9. 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?	O Yes	O No

Have you felt driven to perform certain acts over and over again, such as:		
10. Excessive or ritualized washing, cleaning, or grooming?	O Yes	O No
12. Counting, arranging, evening-up behaviors (making sure socks are at the same height)?	O Yes	O No
13. Collecting useless objects or inspecting the garbage before it is thrown out?	O Yes	O No
14. Repeating routine actions (in/out of chair, going through doorways, relighting cigarettes) a certain number of times until it feels just right?	O Yes	O No
16. Needing to touch objects or people?	O Yes	O No
17. Unnecessary rereading or rewriting; opening envelopes before they are mailed?	O Yes	O No
18. Examining your body for signs of illness?	O Yes	O 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?	O Yes	O No
20. Needing to "confess" or repeatedly asking for reassurance that you said or did something correctly?	O Yes	O No

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CONTINUE TO PART B on PAGE 3

PEACE for MOMS
PEACE for MOMS

providing peace of mind for you and for your patient
providing peace of mind for you and for your patient

Utilizing these five severity items, the individual rates the cumulative severity of endorsed symptoms on five items, time occupied, interference, distress, resistance, and degree of control.

If there is more than one "yes", the client completes the SS on the second page. They will rate the severity of their symptoms identified on the SC. The clinician adds the total and a score of 8+ indicates possible OCD traits.

PART B Instructions: 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.

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

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

2. How much distress do they cause you?

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

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

0 O Complete Control
1 O Much Control
2 O Moderate Control
3 O Little Control
4 O No control

4. How much do they cause you to avoid doing anything, going anyplace or being with anyone

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

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

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

Storch, E. A., Kaufman, D. A. S., Bagner, D., Merlo, L. J., Shapira, N. A., Geffken, G. R., Murphy, T. K., & Goodman, W. K. (2007). Florida Obsessive-Compulsive Inventory: Development, reliability and validity. *Journal of Clinical Psychology, 63*(9), 851 – 859. DOI: 10.1002/jclp.20382