

## Yale-Brown Obsessive Compulsive Scale Checklist (Y-BOCS)

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Name and relationship of person completing this form (if not self): \_\_\_\_\_

Please indicate if you have ever exhibited any of the obsessions or compulsions listed below. Remember, obsessions are unwanted, intrusive thoughts. Compulsions are repetitive behaviors or thoughts that a person uses with the intention of making their obsessions go away.

### Obsessions

#### **Contamination**

	<b>Current</b>	<b>Past Only</b>
Concern or disgust with bodily waste or secretions	<input type="checkbox"/>	<input type="checkbox"/>
Concern with dirt or germs	<input type="checkbox"/>	<input type="checkbox"/>
Excessive concern with household items (e.g., cleansers solvents)	<input type="checkbox"/>	<input type="checkbox"/>
Excessive concern with environmental contaminants	<input type="checkbox"/>	<input type="checkbox"/>
Bothered by sticky substances or residues	<input type="checkbox"/>	<input type="checkbox"/>
Concerned with getting ill (e.g., AIDS)	<input type="checkbox"/>	<input type="checkbox"/>
Concerned you will get others ill by spreading germs	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>

#### **Aggressive/Harming**

	<b>Current</b>	<b>Past Only</b>
Fear might harm self	<input type="checkbox"/>	<input type="checkbox"/>
Fear might harm others	<input type="checkbox"/>	<input type="checkbox"/>
Violent or horrific images	<input type="checkbox"/>	<input type="checkbox"/>
Fear of blurting out obscenities or insults	<input type="checkbox"/>	<input type="checkbox"/>
Fear will harm others because not careful enough (e.g., accidentally running over someone with car)	<input type="checkbox"/>	<input type="checkbox"/>
Fear of being responsible for something else terrible happening (e.g., fire, burglary)	<input type="checkbox"/>	<input type="checkbox"/>
Fear of doing something else embarrassing	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>

#### **Hoarding/Saving**

	<b>Current</b>	<b>Past Only</b>
Excessive collecting or saving	<input type="checkbox"/>	<input type="checkbox"/>
Fear of losing or throwing out items by mistake	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>

#### **Need for Symmetry or Exactness**

	<b>Current</b>	<b>Past Only</b>
Bothered by things not lined up or being in order	<input type="checkbox"/>	<input type="checkbox"/>
The need for things to be perfect or "just right"	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>

**Moral or Religious Obsessions (Scrupulosity)**

Excessive concern with sacrilege or blasphemy (offending God)

**Current**

**Past Only**

Excessive concern with right/wrong, morality

Other: \_\_\_\_\_

**Sexual Obsessions**

**Current**

**Past Only**

Personally unacceptable sexual thoughts/images/impulses

Content involves children or incest

Content involves homosexuality

Content involves aggressive sexual behavior toward others

Other: \_\_\_\_\_

**Somatic**

**Current**

**Past Only**

Excessive concern with illness or disease

Excessive concern with body part(s) or appearance

Other: \_\_\_\_\_

**Other**

**Current**

**Past Only**

Magical thoughts or superstitions (e.g., lucky or unlucky numbers, words, etc.)

The need to tell or confess

Intrusive sounds, words, music, or images

After completing routine activities, doubts whether performed or not

Other: \_\_\_\_\_

**Compulsions:**

**Cleaning/Washing Compulsions**

**Current**

**Past Only**

Excessive or ritualized hand washing

Excessive or ritualized bathing, toothbrushing, grooming, or toilet routine

Cleaning of household items or other inanimate objects

Other: \_\_\_\_\_

**Checking Compulsions**

**Current**

**Past Only**

Checking locks, stove, appliances, water faucets, school/work items

Checking that did not harm self

Checking that did not harm others

Checking that did not make mistake (e.g., balancing checkbook over and over)

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Checking related to somatic obsessions (e.g., self for signs of cancer)	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>Repeating Compulsions</b>	<b>Current</b>	<b>Past Only</b>
Rereading or rewriting	<input type="checkbox"/>	<input type="checkbox"/>
Repeats same question	<input type="checkbox"/>	<input type="checkbox"/>
Need to repeat routine activities (e.g., opening door, turning items on/off)	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>Hoarding/Collecting Compulsions</b>	<b>Current</b>	<b>Past Only</b>
Difficulty throwing things away	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>Ordering/Arranging Compulsions</b>	<b>Current</b>	<b>Past Only</b>
Lines up items in fixed order	<input type="checkbox"/>	<input type="checkbox"/>
Need for symmetry (e.g., shoelaces must be at same tension, socks at same height)	<input type="checkbox"/>	<input type="checkbox"/>
Can't complete activity until just right	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>Miscellaneous Compulsions</b>	<b>Current</b>	<b>Past Only</b>
Mental rituals	<input type="checkbox"/>	<input type="checkbox"/>
Counting compulsions	<input type="checkbox"/>	<input type="checkbox"/>
Excessive list making	<input type="checkbox"/>	<input type="checkbox"/>
Pathological slowness	<input type="checkbox"/>	<input type="checkbox"/>
Need to tell, ask, confess	<input type="checkbox"/>	<input type="checkbox"/>
Superstitious behaviors	<input type="checkbox"/>	<input type="checkbox"/>
Asking for reassurance over and over	<input type="checkbox"/>	<input type="checkbox"/>
Self-damaging behaviors	<input type="checkbox"/>	<input type="checkbox"/>
Rituals involving blinking or staring	<input type="checkbox"/>	<input type="checkbox"/>
Need to touch, tap, or rub	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>