

FLORIDA OBSESSIVE COMPULSIVE INVENTORY (FOCI)

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[This is the Self-Test for OCD]

General Instructions: The questions below are designed to identify some of the common symptoms of Obsessive Compulsive Disorder (OCD). Keep in mind, a high score on this questionnaire does not necessarily mean you have OCD. Only an evaluation by a health professional can make this determination. Answer these questions as accurately as you can.

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

	YES	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?	<input type="checkbox"/>	<input type="checkbox"/>
2. Overconcern with keeping objects (clothing, tools, etc) in perfect order or arranged exactly?	<input type="checkbox"/>	<input type="checkbox"/>
3. Images of death or other horrible events?	<input type="checkbox"/>	<input type="checkbox"/>
4. Personally unacceptable religious or sexual thoughts?	<input type="checkbox"/>	<input type="checkbox"/>
Have you worried a lot about terrible things happening, such as:		
5. Fire, burglary or flooding of the house?	<input type="checkbox"/>	<input type="checkbox"/>
6. Accidentally hitting a pedestrian with your car or letting it roll down a hill?	<input type="checkbox"/>	<input type="checkbox"/>
7. Spreading an illness (giving someone AIDS)?	<input type="checkbox"/>	<input type="checkbox"/>
8. Losing something valuable?	<input type="checkbox"/>	<input type="checkbox"/>
9. Harm coming to a loved one because you weren't careful enough?	<input type="checkbox"/>	<input type="checkbox"/>
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="checkbox"/>	<input type="checkbox"/>
Have you felt driven to perform certain acts over and over again, such as:		
11. Excessive or ritualized washing, cleaning or grooming?	<input type="checkbox"/>	<input type="checkbox"/>
12. Checking light switches, water faucets, the stove, door locks or the emergency brake?	<input type="checkbox"/>	<input type="checkbox"/>
13. Counting, arranging; evening-up behaviors (making sure socks are at same height)?	<input type="checkbox"/>	<input type="checkbox"/>
14. Collecting useless objects or inspecting the garbage before it is thrown out?	<input type="checkbox"/>	<input type="checkbox"/>
15. Repeating routine actions (in/out of chair, going through doorway, relighting cigarette) a certain number of times or until it feels <i>just right</i> ?	<input type="checkbox"/>	<input type="checkbox"/>
16. Needing to touch objects or people?	<input type="checkbox"/>	<input type="checkbox"/>
17. Unnecessary rereading or rewriting; reopening envelopes before they are mailed?	<input type="checkbox"/>	<input type="checkbox"/>
18. Examining your body for signs of illness?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
20. Needing to "confess" or repeatedly asking for reassurance that you said or did something correctly?	<input type="checkbox"/>	<input type="checkbox"/>

If you answered YES to three or more of these questions, please continue with Part B.

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 box next to the most appropriate number from 0 to 4.

<i>In the past month...</i>					
1. On average, how much <i>time</i> is occupied by these thoughts or behaviors each day?	0 None <input type="checkbox"/>	1 Mild (less than 1 hour) <input type="checkbox"/>	2 Moderate (1 to 3 hours) <input type="checkbox"/>	3 Severe (3 to 8 hours) <input type="checkbox"/>	4 Extreme (more than 8 hours) <input type="checkbox"/>
2. How much <i>distress</i> do they cause you?	0 None <input type="checkbox"/>	1 Mild <input type="checkbox"/>	2 Moderate <input type="checkbox"/>	3 Severe <input type="checkbox"/>	4 Extreme (disabling) <input type="checkbox"/>
3. How hard is it for you to <i>control</i> them?	0 Complete control <input type="checkbox"/>	1 Much control <input type="checkbox"/>	2 Moderate control <input type="checkbox"/>	3 Little control <input type="checkbox"/>	4 No control <input type="checkbox"/>
4. How much do they cause you to <i>avoid</i> doing anything, going anyplace or being with anyone?	0 No avoidance <input type="checkbox"/>	1 Occasional avoidance <input type="checkbox"/>	2 Moderate avoidance <input type="checkbox"/>	3 Frequent and extensive avoidance <input type="checkbox"/>	4 Extreme avoidance (house-bound) <input type="checkbox"/>
5. How much do they <i>interfere</i> with school, work or your social or family life?	0 None <input type="checkbox"/>	1 Slight interference <input type="checkbox"/>	2 Definitely interferes with functioning <input type="checkbox"/>	3 Much interference <input type="checkbox"/>	4 Extreme interference (disabling) <input type="checkbox"/>

Sum on Part B

(Add Items 1 to 5): _____

After answering the questions in Part B, total your score. It should range from 0 to a maximum of 20. If you score 8 or more, it is recommended that you consider consultation with a mental health professional.