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Child OCD Rating Scale

Patient _____

Date _____

Current	Past	Contamination Obsessions	Current	Past	Sexual Obsessions
<input type="checkbox"/>	<input type="checkbox"/>	Concern with dirt, germs, certain illnesses (e.g., AIDS)			(Are you having any sexual thoughts? If yes, are they routine or are they repetitive thoughts that you would rather not have or find disturbing? If yes, are they)
<input type="checkbox"/>	<input type="checkbox"/>	Concerns or disgust with bodily waste or secretions (e.g., urine, feces, saliva)			Forbidden or perverse sexual thoughts, images, impulses
<input type="checkbox"/>	<input type="checkbox"/>	Excessive concern with environmental contaminants (e.g., asbestos, radiation, toxic waste)	<input type="checkbox"/>	<input type="checkbox"/>	Content involves homosexuality
<input type="checkbox"/>	<input type="checkbox"/>	Excessive concern with household items (e.g., cleaners, solvents)	<input type="checkbox"/>	<input type="checkbox"/>	Sexual behavior towards others (Aggressive)
<input type="checkbox"/>	<input type="checkbox"/>	Excessive concerns about animals/insects	<input type="checkbox"/>	<input type="checkbox"/>	Other (describe) _____
<input type="checkbox"/>	<input type="checkbox"/>	Excessively bothered by sticky substances or residues			Hoarding/Saving Obsessions
<input type="checkbox"/>	<input type="checkbox"/>	Concerned will get ill because of contaminant	<input type="checkbox"/>	<input type="checkbox"/>	Fear of losing things
<input type="checkbox"/>	<input type="checkbox"/>	Concerned will get others ill by spreading contaminant (aggressive)	<input type="checkbox"/>	<input type="checkbox"/>	Other (describe) _____
<input type="checkbox"/>	<input type="checkbox"/>	No concern with consequences of contamination other than how it might feel			Magical Thoughts / Superstitious Obsessions
<input type="checkbox"/>	<input type="checkbox"/>	Other (describe) _____	<input type="checkbox"/>	<input type="checkbox"/>	Lucky/unlucky numbers, colors, words
		Aggressive Obsessions	<input type="checkbox"/>	<input type="checkbox"/>	Other (describe) _____
<input type="checkbox"/>	<input type="checkbox"/>	Fear might harm self	<input type="checkbox"/>	<input type="checkbox"/>	Somatic Obsessions
<input type="checkbox"/>	<input type="checkbox"/>	Fear might harm others	<input type="checkbox"/>	<input type="checkbox"/>	Excessive concern with illness or disease
<input type="checkbox"/>	<input type="checkbox"/>	Fear harm will come to self	<input type="checkbox"/>	<input type="checkbox"/>	Excessive concern with body part or aspect of appearance (e.g., dysmorphophobia)
<input type="checkbox"/>	<input type="checkbox"/>	Fear harm will come to others (may be because of something child did or did not do)	<input type="checkbox"/>	<input type="checkbox"/>	Other (describe) _____
<input type="checkbox"/>	<input type="checkbox"/>	Violent or horrific images			Religious Obsessions (Scruplesity)
<input type="checkbox"/>	<input type="checkbox"/>	Fear of blurting out obscenities or insults	<input type="checkbox"/>	<input type="checkbox"/>	Excessive concern or fear of offending religious objects (God)
<input type="checkbox"/>	<input type="checkbox"/>	Fear of doing something else embarrassing	<input type="checkbox"/>	<input type="checkbox"/>	Excessive concern with right/wrong, morality
<input type="checkbox"/>	<input type="checkbox"/>	Fear will act on unwanted impulses (e.g. to stab a family member)	<input type="checkbox"/>	<input type="checkbox"/>	Other (describe) _____
<input type="checkbox"/>	<input type="checkbox"/>	Fear will steal things			Miscellaneous Obsessions
<input type="checkbox"/>	<input type="checkbox"/>	Fear will be responsible for something else terrible happening (e.g., fire, burglary, flood)	<input type="checkbox"/>	<input type="checkbox"/>	The need to know or remember
<input type="checkbox"/>	<input type="checkbox"/>	Other (describe) _____	<input type="checkbox"/>	<input type="checkbox"/>	Fear of saying certain things
			<input type="checkbox"/>	<input type="checkbox"/>	Fear of not saying just the right thing
			<input type="checkbox"/>	<input type="checkbox"/>	Intrusive (non-violent) images
			<input type="checkbox"/>	<input type="checkbox"/>	Intrusive sounds, words, music or numbers
			<input type="checkbox"/>	<input type="checkbox"/>	Other (describe) _____

Target Symptom List for Obsessions

OBSESSIONS (describe, listing by order of severity, with #1 being the most severe, #2 second most severe, etc.):

1. _____
2. _____
3. _____
4. _____

Name: _____

Date: _____

CY-BOCS Compulsions Checklist

Check all symptoms that apply (Items marked "*" may or may not be OCD Phenomena)

Current	Past	Washing/Cleaning Compulsions	Hoarding/Saving Compulsions
<input type="checkbox"/>	<input type="checkbox"/>	Excessive or ritualized handwashing	(distinguish from hobbies and concern with objects of monetary or sentimental value)
<input type="checkbox"/>	<input type="checkbox"/>	Excessive or ritualized showering, bathing, toothbrushing, grooming, toilet routine	<input type="checkbox"/> <input type="checkbox"/> Difficulty throwing things away, saving bits of paper, string, etc.
<input type="checkbox"/>	<input type="checkbox"/>	Excessive cleaning of items, such as personal clothes or important objects	<input type="checkbox"/> <input type="checkbox"/> Other (describe) _____
<input type="checkbox"/>	<input type="checkbox"/>	Other measures to prevent or remove contact with contaminants	Excessive Games / Superstitious Behaviors (distinguish from age appropriate magical games) (e.g., any of behavior, such as stepping over certain spots on a floor, touching an object/cell certain number of times as a routine (done to avoid something bad from happening))
<input type="checkbox"/>	<input type="checkbox"/>	Other (describe) _____	<input type="checkbox"/> <input type="checkbox"/> Other (describe) _____
<input type="checkbox"/>	<input type="checkbox"/>	Checking compulsions	Rituals Involving Other Persons The need to involve another person (usually a parent) in ritual (e.g., asking a parent to repeatedly answer the same question, making mother perform certain meal-time rituals involving specific utensils)*
<input type="checkbox"/>	<input type="checkbox"/>	Checking locks, toys, school books/items, etc.	<input type="checkbox"/> <input type="checkbox"/> Other (describe) _____
<input type="checkbox"/>	<input type="checkbox"/>	Checking associated with getting washed, dressed, or undressed	Miscellaneous Compulsions
<input type="checkbox"/>	<input type="checkbox"/>	Checking that did not/will not harm others	Mental rituals (other than checking/counting)
<input type="checkbox"/>	<input type="checkbox"/>	Checking that did not/will not harm self	Need to tell, ask, or confess
<input type="checkbox"/>	<input type="checkbox"/>	Checking that nothing terrible did/will happen	Measures (not checking) to prevent harm to self <input type="checkbox"/> harm to others <input type="checkbox"/> (avoidable consequences) <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Checking that did not make mistake	Ritualized eating behaviors *
<input type="checkbox"/>	<input type="checkbox"/>	Checking tied to somatic obsessions	Excessive list making *
<input type="checkbox"/>	<input type="checkbox"/>	Other (describe) _____	Need to touch, tap, rub*
<input type="checkbox"/>	<input type="checkbox"/>	Repeating Rituals	Need to do things (e.g., touch or arrange until it feels just right)*
<input type="checkbox"/>	<input type="checkbox"/>	Rereading, erasing, or rewriting	Rituals involving blinking or staring *
<input type="checkbox"/>	<input type="checkbox"/>	Need to repeat routine activities (e.g., in/out of doorway, up/down from chair)	Trichotillomania (hair-pulling) *
<input type="checkbox"/>	<input type="checkbox"/>	Other (describe) _____	Other self-damaging or self-mutilating behavior *
<input type="checkbox"/>	<input type="checkbox"/>	Counting Compulsions	Other (describe) _____
<input type="checkbox"/>	<input type="checkbox"/>	Objects, certain numbers, words, etc.	
<input type="checkbox"/>	<input type="checkbox"/>	Describe _____	
<input type="checkbox"/>	<input type="checkbox"/>	Ordering/Arranging	
<input type="checkbox"/>	<input type="checkbox"/>	Need for symmetry/evening up (e.g., lining items up a certain way or arranging personal items in specific patterns)	
<input type="checkbox"/>	<input type="checkbox"/>	Other (describe) _____	

Target Symptom List for Compulsions

(describe, listing by order of severity, with #1 being the most severe, #2 second most severe, etc.):

- 1 _____
- 2 _____
- 3 _____
- 4 _____