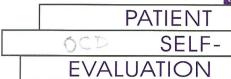
QUESTIONNAIRE PART A

11

13

15

20



YES

NO

Patient's name:	Date:	
Instructions: The questions below are designed with anxiety symptoms. Keep in mind, a high some necessarily mean you have an anxiety disorder can make this determination. Answer the questions will help your doctor make a diagnosis.	score on this questionnaire does not er—only an evaluation by a physician	
Please circle YES or NO for the following quin the past MONTH:	estions, based on your experience	
Have you been bothered by unpleasant tho enter your mind, such as:	ughts or images that repeatedly	
Concerns with contamination (dirt, germs, che serious illness such as AIDS?	emicals, radiation) or acquiring a	YES NO
Overconcern with keeping objects (clothing, g	proceries, tools) in perfect order or arranged exactly?	YES NO
Images of death or other horrible events?		YES NO
Personally unacceptable religious or sexual that	oughts?	YES NO
Have you worried a lot about terrible things	happening, such as:	
Fire, burglary or flooding of the house?		YES NO
Accidentally hitting a pedestrian with your car	or letting it roll down a hill?	YES NO
Spreading an illness (giving someone AIDS)?		YES NO
Losing something valuable?		YES NO
Harm coming to a loved one because you w	eren't careful enough?	YES NO
_	nted and senseless urge or impulse, such as:	
Physically harming a loved one, pushing a stro car into oncoming traffic; inappropriate sexua		YES NO
санно опсотнид наше, наррюрнате зелаа	r cornact, or posoning airliner guesis:	123 110
Have you felt driven to perform certain acts	over and over again, such as:	
Excessive or ritualized washing, cleaning or gro		YES NO
Checking light switches, water faucets, the stor	0	YES NO
Counting; arranging; evening-up behaviors (m		YES NO
Collecting useless objects or inspecting the go	0 ,	YES NO
Repeating routine actions (in/out of chair, goin a certain number of times or until it feels <i>just r</i> .	g through doorway, relighting cigarette)	YES NO
Needing to touch objects or people?	9111:	YES NO
Unnecessary rereading or rewriting; reopening	envelones before they are mailed?	YES NO
Examining your body for signs of illness?	chivolopes before they die Hidiled?	YES NO
Avoiding colors ("red" means blood), numbers	("13" is unlucky) or names (those that start	I ILO I NO
with "D" signify death) that are associated with		YES NO

If you answered YES to TWO OR MORE questions, please continue with Part B on the next side.

Needing to "confess" or repeatedly asking for reassurance that you said or did something correctly?



QUESTIONNAIRE PART B

PATIENT SELF-EVALUATION

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.

Circle the most appropriate number from 0 to 4.

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

For physician use: Sum on Part B (Add items 1 to 5):

Keep in mind, a high score on this questionnaire does not necessarily mean you have an anxiety disorder—only an evaluation by a physician can make this determination.

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