FLORIDA OBSESSIVE-COMPULSIVE INVENTORY

FOCI

Name: **Date:**

General Instructions: The questions below are designed to help health professionals evaluate anxiety symptoms. Keep in mind, a high score on this questionnaire does not necessarily mean you have an anxiety disorder — only an evaluation by a health professional can make this determination. Answer these questions as accurately as you can.

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

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?	YES	NO
2	Overconcern with keeping objects (clothing, tools, etc) in perfect order or arranged exactly?	YES	NO
3	Images of death or other horrible events?	YES	NO
4	Personally unacceptable religious or sexual thoughts?	YES	NO

Have you worried a lot about terrible things happening, such as:

5	Fire, burglary or flooding of the house?	YES	NO
6	Accidentally hitting a pedestrian with your car or letting it roll down a hill?	YES	NO
7	Spreading an illness (giving someone AIDS)?	YES	NO
8	Losing something valuable?	YES	NO
9	Harm coming to a loved one because you weren't careful enough?	YES	NO

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?	YES	NO

Have you felt driven to perform certain acts over and over again, such as:

11	Excessive or ritualized washing, cleaning or grooming?	YES	NO
12	Checking light switches, water faucets, the stove, door locks or the emergency brake?	YES	NO
13	Counting, arranging; evening-up behaviors (making sure socks are at same height)?	YES	NO
14	Collecting useless objects or inspecting the garbage before it is thrown out?	YES	NO
15	Repeating routine actions (in/out of chair, going through doorway, relighting cigarette) a certain number of times or until it feels ***just right?***	YES	NO
16	Needing to touch objects or people?	YES	NO
17	Unnecessary rereading or rewriting; reopening envelopes before they are mailed?	YES	NO
18	Examining your body for signs of illness?	YES	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?	YES	NO
20	Needing to “confess” or repeatedly asking for reassurance that you said or did something correctly?	YES	NO

If you answered YES to one 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.

Circle the most appropriate number from 0 to 4.

In the past month...					
1. On average, how much *time* is occupied by these thoughts or behaviors each day?	0 None	1 Mild (less than 1 hour)	2 Moderate (1 to 3 hours)	3 Severe (3 to 8 hours)	4 Extreme (more than 8 hours)
2. How much *distress* do they cause you?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme (disabling)
3. How hard is it for you to *control* them?	0 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?	0 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?	0 None	1 Slight interference	2 Definitely interferes with functioning	3 Much interference	4 Extreme interference (disabling)

For clinician use:
Sum on Part B
(Add Items 1 to 5):_____

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