Anxiety Disorders Center

Please complete this form and show it to your doctor or other healthcare professional.

Do you have Obsessive-Compulsive Disorder?

1.	Do you experience recurrent and persistent thoughts, impulses, or images?	**YES**	**NO**
2.	Do the thoughts, impulses, or images seem intrusive and inappropriate?	**YES**	**NO**
3.	Do the thoughts, impulses, or images cause you to feel very anxious or distressed?	**YES**	**NO**
4.	Do you try to ignore or suppress the thoughts, impulses, or images, or to neutralize them with some other thought or action?	**YES**	**NO**
5.	Do the thoughts, impulses, or images come from your own mind?	**YES**	**NO**
6.	Are the thoughts, impulses, or images excessive or unreasonable?	**YES**	**NO**
7.	Are the thoughts, impulses, or images excessive worries about real-life problems?	**YES**	**NO**
8.	Do you engage in repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently)?	**YES**	**NO**
9.	Do you feel driven to perform the repetitive behaviors or mental acts in response to an obsession or according to rules that must be applied rigidly?	**YES**	**NO**
10.	Are the behaviors or mental acts aimed at preventing or reducing distress or preventing some dreaded event or situation?	**YES**	**NO**
11.	Are the behaviors or mental acts excessive or unreasonable?	**YES**	**NO**
12.	Do your intrusive thoughts or repetitive behaviors cause you to feel very distressed or anxious?	**YES**	**NO**
13.	Do your intrusive thoughts or repetitive behaviors take more than one hour a day?	**YES**	**NO**
14.	Do your intrusive thoughts or repetitive behaviors significantly interfere with your normal routine, occupational (or academic) functioning, or usual social activities or relationships?	**YES**	**NO**

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You *might* have Obsessive-Compulsive Disorder if **all** of the following are **true**:

One or both of the following are true:

- You answered YES to items 1, 2, 3, 4, 5, and 6, AND you answered NO to item 7
- You answered YES to items 8, 9, 10, and 11

AND

- You answered YES to any of items 12, 13, and 14

Note: This questionnaire is for informational purposes only and is not intended to function as a psychological or psychiatric assessment. Diagnosis of psychiatric disorders requires a careful evaluation by a trained professional.

To get help for this condition or to receive a comprehensive assessment, please call The Institute of Living's Anxiety Disorders Center at (860) 545-7685.

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