Children's Florida Obsessive-Compulsive Inventory (C-FOCI)

Name: _____Date: _____

General Instructions: The questions below are designed to help your doctors evaluate anxiety symptoms. Please answer these questions as honestly as you can.

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 dirt, germs, chemicals or getting really sick?	**Yes**	**No**
2	Overconcern with keeping objects (clothes, toys, books) in perfect order or arranged exactly?	**Yes**	**No**
3	Frequent images of death or other horrible things?	**Yes**	**No**
Have you worried a lot about terrible things happening, such as:			
4	Fire, someone robbing you or flooding of the house?	**Yes**	**No**
5	Accidentally hitting a pedestrian with your car or hurting someone?	**Yes**	**No**
6	Spreading an illness (giving someone AIDS)?	**Yes**	**No**
7	Losing something valuable?	**Yes**	**No**
8	Harm coming to a loved one because you weren't careful enough?	**Yes**	**No**
Have you felt driven to perform certain acts over and over again, such as:			
9	Excessive or ritualized washing, cleaning or grooming?	**Yes**	**No**
10	Checking light switches, water faucets, the stove, or door locks?	**Yes**	**No**
11	Counting, arranging; evening-up behaviors (making sure socks are at same height)?	**Yes**	**No**
12	Repeating routine actions (in/out of chair, going through doorway, opening/closing things) a certain number of times or until it feels just right?	**Yes**	**No**
13	Needing to touch objects or people?	**Yes**	**No**
14	Unnecessary rereading or rewriting?	**Yes**	**No**
15	Examining your body for signs of illness?	**Yes**	**No**
16	Avoiding colors ("red" means blood), numbers ("13" is unlucky) or names (those that start with "D" signify death) that are associated with scary events or thoughts?	**Yes**	**No**
17	Needing to "confess" or repeatedly asking for reassurance that you said or did something correctly?	**Yes**	**No**

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 month 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 do these things *bother* 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 things, going places or being with people?	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, your social or family life, or your job?	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): _____