

CY-BOCS Symptom Checklist

Children's Yale-Brown Obsessive Compulsive Scale

Administering the CY-BOCS Symptom Checklist and CY-BOCS Severity Ratings

1. Establish the diagnosis of obsessive compulsive disorder.
2. Using the CY-BOCS Symptom Checklist (below), ascertain current and past symptoms.
3. Next, administer the 10 item severity ratings (other form) to assess the severity of the OCD during the last week.
4. Re-administer the CY-BOCS Severity Rating Scale to monitor progress.

Patient _____ Date _____

CY-BOCS Symptom Checklist

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CY-BOCS Obsessions Checklist

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

Current	Past	Contamination Obsessions	Current	Past	Sexual Obsessions
<input type="checkbox"/>	<input type="checkbox"/>	Concern with dirt, germs, certain illnesses (e.g., AIDS)	<input type="checkbox"/>	<input type="checkbox"/>	Forbidden or perverse sexual thoughts, images, impulses
<input type="checkbox"/>	<input type="checkbox"/>	Concerns or disgust with bodily waste or secretions (e.g. urine, feces, saliva)	<input type="checkbox"/>	<input type="checkbox"/>	Content involves homosexuality
<input type="checkbox"/>	<input type="checkbox"/>	Excessive concern with environmental contaminants (e.g., asbestos, radiation, toxic waste)	<input type="checkbox"/>	<input type="checkbox"/>	Sexual behavior towards others (aggressive)
<input type="checkbox"/>	<input type="checkbox"/>	Excessive concern with household items (e.g., cleaners, solvents)	<input type="checkbox"/>	<input type="checkbox"/>	Other (describe) _____
<input type="checkbox"/>	<input type="checkbox"/>	Excessive concern about animals / insects	Hoarding / Saving Obsessions		
<input type="checkbox"/>	<input type="checkbox"/>	Excessively bothered by sticky substances or residues	<input type="checkbox"/>	<input type="checkbox"/>	Fear of losing things
<input type="checkbox"/>	<input type="checkbox"/>	Concerned will get ill because of contaminant	<input type="checkbox"/>	<input type="checkbox"/>	Other (describe) _____
<input type="checkbox"/>	<input type="checkbox"/>	Concerned will get others ill by spreading contaminant (aggressive)	Magical Thoughts / Superstitious Obsessions		
<input type="checkbox"/>	<input type="checkbox"/>	No concern with consequences of contamination other than how it might feel *	<input type="checkbox"/>	<input type="checkbox"/>	Lucky / unlucky numbers, colors, words
<input type="checkbox"/>	<input type="checkbox"/>	Other (describe) _____	<input type="checkbox"/>	<input type="checkbox"/>	Other (describe) _____
Aggressive Obsessions			Somatic Obsessions		
<input type="checkbox"/>	<input type="checkbox"/>	Fear might harm self	<input type="checkbox"/>	<input type="checkbox"/>	Excessive concern with illness or disease *
<input type="checkbox"/>	<input type="checkbox"/>	Fear might harm others	<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 self	<input type="checkbox"/>	<input type="checkbox"/>	Other (describe) _____
<input type="checkbox"/>	<input type="checkbox"/>	Fear harm will come to others (maybe because of something child did or did not do)	Religious Obsessions		
<input type="checkbox"/>	<input type="checkbox"/>	Violent or horrific images	<input type="checkbox"/>	<input type="checkbox"/>	Excessive concern or fear of offending religious objects
<input type="checkbox"/>	<input type="checkbox"/>	Fear of blurting out obscenities or insults	<input type="checkbox"/>	<input type="checkbox"/>	Excessive concern with right / wrong morally
<input type="checkbox"/>	<input type="checkbox"/>	Fear of doing something embarrassing *	<input type="checkbox"/>	<input type="checkbox"/>	Other (describe) _____
<input type="checkbox"/>	<input type="checkbox"/>	Fear will act on unwanted impulses (e.g., to stab a family member)	Miscellaneous Obsessions		
<input type="checkbox"/>	<input type="checkbox"/>	Fear will steal things	<input type="checkbox"/>	<input type="checkbox"/>	The need to know or remember
<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"/>	Fear of saying certain things
<input type="checkbox"/>	<input type="checkbox"/>	Other (describe) _____	<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 sever, #2 second most severe, etc):

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

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CY-BOCS Compulsions Checklist

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

Current	Past	Washing / Cleaning Compulsions	Current	Past	Hoarding / Saving Compulsions
<input type="checkbox"/>	<input type="checkbox"/>	Excessive or ritualized hand washing			Distinguish from hobbies and concern with objects of monetary or sentimental value.
<input type="checkbox"/>	<input type="checkbox"/>	Excessive or ritualized showering, bathing, tooth brushing, 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
<input type="checkbox"/>	<input type="checkbox"/>	Other (describe) _____	<input type="checkbox"/>	<input type="checkbox"/>	Distinguish from age appropriate magical games (e.g. array of behavior, such as sleeping over certain spots on a floor, touching an object / self certain number of times as a routine game to avoid something bad from happening)
		Checking Compulsions	<input type="checkbox"/>	<input type="checkbox"/>	Other (describe) _____
<input type="checkbox"/>	<input type="checkbox"/>	Checking locks, toys, school books / items, etc.			Rituals Involving Other Persons
<input type="checkbox"/>	<input type="checkbox"/>	Checking associated with getting washed, dressed, or undressed	<input type="checkbox"/>	<input type="checkbox"/>	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 mealtime rituals involving specific utensils) *
<input type="checkbox"/>	<input type="checkbox"/>	Checking that did not / will not harm others	<input type="checkbox"/>	<input type="checkbox"/>	Other (describe) _____
<input type="checkbox"/>	<input type="checkbox"/>	Checking that did not / will not harm self	<input type="checkbox"/>	<input type="checkbox"/>	Miscellaneous Compulsions
<input type="checkbox"/>	<input type="checkbox"/>	Checking that nothing terrible did / will happen	<input type="checkbox"/>	<input type="checkbox"/>	Mental rituals other than checking / counting
<input type="checkbox"/>	<input type="checkbox"/>	Checking that did not make mistake	<input type="checkbox"/>	<input type="checkbox"/>	Need to tell, ask or confess
<input type="checkbox"/>	<input type="checkbox"/>	Checking tied to somatic obsessions	<input type="checkbox"/>	<input type="checkbox"/>	Measures (not checking) to prevent :
<input type="checkbox"/>	<input type="checkbox"/>	Other (describe) _____	<input type="checkbox"/>	<input type="checkbox"/>	harm to self
		Repeating Rituals	<input type="checkbox"/>	<input type="checkbox"/>	harm to others
<input type="checkbox"/>	<input type="checkbox"/>	Rereading, erasing, or rewriting	<input type="checkbox"/>	<input type="checkbox"/>	terrible consequences
<input type="checkbox"/>	<input type="checkbox"/>	Need to repeat activities (e.g. in / out of doorway, up / down from chair)	<input type="checkbox"/>	<input type="checkbox"/>	Ritualized eating behaviors *
<input type="checkbox"/>	<input type="checkbox"/>	Other (describe) _____	<input type="checkbox"/>	<input type="checkbox"/>	Excessive list making *
		Counting Compulsions	<input type="checkbox"/>	<input type="checkbox"/>	Need to touch, tap, rub *
<input type="checkbox"/>	<input type="checkbox"/>	Objects, certain numbers, words, etc.	<input type="checkbox"/>	<input type="checkbox"/>	Need to do things (e.g. touch or arrange until it feels just right) *
<input type="checkbox"/>	<input type="checkbox"/>	Other (describe) _____	<input type="checkbox"/>	<input type="checkbox"/>	Rituals involving blinking or staring *
		Ordering / Arranging	<input type="checkbox"/>	<input type="checkbox"/>	Trichotillomania (hair-pulling)
<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 self-damaging or self-mutilating behaviors *
<input type="checkbox"/>	<input type="checkbox"/>	Other (describe) _____	<input type="checkbox"/>	<input type="checkbox"/>	Other (describe) _____

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Target Symptom List for Compulsions

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

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

CY-BOCS Severity Ratings

Children's Yale-Brown Obsessive Compulsive Scale

Administering the CY-BOCS Symptom Checklist and CY-BOCS Severity Ratings

1. Establish the diagnosis of obsessive compulsive disorder.
2. Using the CY-BOCS Symptom Checklist (other form), ascertain current and past symptoms.
3. Next, administer the 10-item severity ratings (below) to assess the severity of the OCD during the last week.
4. Readminister the CY-BOCS Severity Rating Scale to monitor progress.

Patient _____

Date 1st Report _____

Date This Report _____

Obsession Rating Scale (circle appropriate score)

Note: Scores should reflect the composite effect of all the patient's obsessive compulsive symptoms.
Rate the average occurrence of each item during the prior week up to and including the time of interview.

QUESTIONS ON OBSESSIONS (ITEMS 1-5) "I AM NOW GOING TO ASK YOU QUESTIONS ABOUT THE THOUGHTS YOU CANNOT STOP THINKING ABOUT."
(Review for the informant(s) the Target Symptoms and refer to them while asking questions 1-5).

1. Time Occupied by Obsessive Thoughts					
[Be sure to exclude ruminations and preoccupations which, unlike obsessions, are ego-syntonic and rational (but exaggerated)]					
	None	Mild	Moderate	Severe	Extreme
		less than 1 hr/day or occasional intrusion	1 to 3 hrs/day or frequent intrusion	greater than 3 and up to 8 hrs/day or very frequent intrusion	greater than 8 hrs/day or near constant intrusion
Score	0	1	2	3	4
2. Interference Due to Obsessive Thoughts					
<ul style="list-style-type: none"> • How much do these thoughts get in the way of school or doing things with friends? • Is there anything that you don't do because of them? (If currently not in school, determine how much performance would be affected if patient were in school) 					
	None	Mild	Moderate	Severe	Extreme
		slight interference with social or school activities, but overall performance not impaired	definite interference with social or school performance, but still manageable	causes substantial impairment in social or school performance	incapacitating
Score	0	1	2	3	4
3. Distress Associated with Obsessive Thoughts					
	None	Mild	Moderate	Severe	Extreme
		infrequent, and not too disturbing	frequent, and disturbing, but still manageable	very frequent, and very disturbing	near constant, and disabling distress/frustration
Score	0	1	2	3	4
4. Resistance Against Obsessions					
<ul style="list-style-type: none"> • How hard do you try to stop the thoughts or ignore them? (Only rate effort made to resist, not success or failure in actually controlling the obsessions. If the obsessions are minimal, the patient may not feel the need to resist them. In such cases, a rating of "0" should be given.) 					
	None	Mild	Moderate	Severe	Extreme
	makes an effort to always resist, or symptoms so minimal doesn't need to actively resist	tries to resist most of the time	makes some effort to resist	yields to all obsessions without attempting to control them, but does so with some reluctance	completely and willingly yields to all obsessions
Score	0	1	2	3	4
5. Degree of Control Over Obsessive Thoughts					
	Complete Control	Much Control	Moderate Control	Little Control	No Control
		usually able to stop or divert obsessions with some effort and concentration	sometimes able to stop or divert obsessions	rarely successful in stopping obsessions, can only divert attention with difficulty	experienced as completely involuntary, rarely able to even momentarily divert thinking
Score	0	1	2	3	4

Obsession subtotal (add items 1-5) _____

