Santé et Services sociaux Québec

Patient's last name	File number
Patient's first name	
Health insurance number	Exp. Year Month
Date of birth Year Month Day	Sex ☐ M ☐ F ☐ X ☐ I
Address (no., street)	
City	Postal Code

OBSESSIVE-COMPULSIVE SYMPTOM ASSESEMENT QUESTIONNAIRE OCI-R

How much have these experiences distressed or bothered you?

1. Answer each item based on the last month or the period of time since your last consultation.
2. Use the scale at the top of the table.
3. Answer each item by checking the box that represents your situation the best.

Items	Not at all 0	A little 1	Moderately 2	A lot 3	Extremely 4
1. I have saved up so many things that they get in the way.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
2. I check things more often than necessary.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
3. I get upset if objects are not arranged properly.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
4. I feel compelled to count while I am doing things.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
5. I find it difficult to touch an object when I know it has been touched by strangers or certain people.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
6. I find it difficult to control my own thoughts.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
7. I collect things I don't need.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
8. I repeatedly check doors, windows, drawers, etc.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

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Items	Not at all 0	A little 1	Moderately 2	A lot 3	Extremely 4
9. I get upset if others change the way I have arranged things.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
10. I feel I have to repeat certain numbers.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
11. I sometimes have to wash or clean myself simply because I feel contaminated.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
12. I am upset by unpleasant thoughts that come into my mind against my will.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
13. I avoid throwing things away because I am afraid I might need them later.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
14. I repeatedly check gas and water taps and light switches after turning them off.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
15. I need things to be arranged in a particular way.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
16. I feel that there are good and bad numbers.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
17. I wash my hands more often and longer than necessary.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
18. I frequently get nasty thoughts and have difficulty in getting rid of them.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

Questionnaire completed by:	**Date:**		
Signature	Year	Month	Day

Patient's last name	Patient's first name	File number

Section reserved for the practitioner

Total score ……..		
Total number of items …….. **x**	**18**	
Number of answered items (≥ 16)* ……. ***/***		
Adjusted Score …….. **=**		

Is the adjusted score greater than the clinical cut-off value of 17? ……..... ☐ Yes ☐ No

Practitioner's qualitative analysis and commentary:

* If 3 or more answers are missing, the score of the questionnaire cannot be used.

Questionnaire reviewed by:				**Date:**		
Practitioner's last name	Practitioner's first name	Licence number	Signature	Year	Month	Day