YBOCS Scoring

PATIENT INFORMATION

Name: _____ **Date of Assessment:** _____ dd / mm / yyyy

Gender: _____ **Age:** _____

CLINICAL HISTORY

Clinical History

Obsessive Thoughts (Score 0-20)

- ◯ 0: None
- ◯ 5: Mild
- ◯ 10: Moderate
- ◯ 15: Severe
- ◯ 20: Extreme

Comments:

Compulsive Behaviors (Score 0-20)

- ◯ 0: None
- ◯ 5: Mild
- ◯ 10: Moderate
- ◯ 15: Severe
- ◯ 20: Extreme

Comments:

Resistance/Control (Score 0-10)

◯ 0: Complete control ◯ 5: Some control ◯ 10: Little or no control

Comments:

Total YBOCS Score (0-50): _____

Clinical Impression

Treatment Recommendations

Follow-Up Plan

Additional Notes