

# OCD Identification Tool

People with OCD experience repetitive and intrusive thoughts, images, urges, or feelings that can be uncomfortable to share. Please answer these questions to see if you might benefit from OCD treatment.

Name

Date of Birth

Insurance

Yes

No

**I have frequent thoughts, urges, or images that I don't want to have.**

For example . . .

- Being contaminated even though I may not be
- Acting out sexually, in a way that's against my character
- Having thoughts that violate my religious beliefs, or thoughts that I may hurt someone else, even though I don't want to, that trouble me

Yes

No

**I do repetitive behaviors.**

For example . . .

- Hand washing or cleaning
- Ordering or arranging
- Checking things
- Avoiding certain people or things
- Searching for answers online
- Asking people for reassurance
- Repeating behaviors over and over
- I repeatedly do things in my mind in order to feel better or to prevent something bad from happening that is problematic, such as
  - Counting
  - Reviewing past events
  - Reassuring myself in my head
  - Saying certain words or phrases

Yes

No

**Over the last month, these obsessive thoughts and/or compulsive behaviors have resulted in:**

- Noticeable distress or interfered with my functioning at home, work, school, socially, in my relationships, or in any other significant manner, and/or consumed more than an hour of my time daily?

Yes

No

**If you answered yes to two or more of the above questions, you may benefit from a conversation about OCD.**

Please indicate to your provider if you have an interest in receiving an assessment from an OCD specialist to further evaluate your symptoms.

Y/N **Provider recommends ERP Treatment based on conversation with patient**

Provider Notes: Why or why not?