

YBOCS Scoring

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

Gender: _____ Age: _____

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