Daily Record of Primary Obsession

Name of client:
Date:
Primary obsession:

Instructions: In consultation with your therapist, please record the obsessional thought, image, or impulse that is most troubling for you at this time. Then list the situations, objects, or circumstances that most often trigger the primary obsession. Please complete the rating scale associated with each situation.

Day of the Week	Approximate frequency of obsession during the day	Average distress of obsessions; 0= none to 100= extreme, panic like	Intensity of efforts to control obsessions; 0= no effort to control to 100= frantic efforts to stop thinking about the obsession	Intensity of urge to engage in compulsion or neutralization; 0 = no urge to 100= irresistible
Sunday				
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				

***For learning more about Cognitive Behaviour Therapy for OCD mail us for a workshop and one-on-one learning session.**

SOLACE SHELTER