

Overt Aggression Scale (OAS)
Stuart Yudofsky, M.D., Jonathan Silver, M.D., Wynn Jackson, M.D., and Jean Endicott, Ph.D.
IDENTIFYING DATA

Name of Patient	Name of Rater
Sex of Patient: 1 Male 2 Female	Date 08/02/2025 (mo/da/yr) Shift : 1 Night 2 Day 3 Evening

No aggressive incident(s) (verbal or physical) against self, others, or objects during the shift. (check here)

AGGRESSIVE BEHAVIOUR (check all that apply)

VERBAL AGGRESSION	PHYSICAL AGGRESSION AGAINST SELF
<input type="checkbox"/> Makes loud noises, shouts angrily <input type="checkbox"/> Yells mild personal insults, e.g., "you're stupid!" <input type="checkbox"/> Cruises viciously, uses foul language in anger, makes moderate threats to others or self <input type="checkbox"/> Makes clear threats of violence toward others or self (I'm going to kill you.) or requests to help to control self	<input type="checkbox"/> Picks or scratches skin, hits self, pulls hair, (with no or minor injury only) <input type="checkbox"/> Bangs head, hits fist into objects, throws self onto floor or into objects (hurts self without serious injury) <input type="checkbox"/> Small cuts or bruises, minor burns <input type="checkbox"/> mutilates self, makes deep cuts, bites that bleed. internal injury fracture, loss of consciousness, loss of teeth

PHYSICAL AGGRESSION AGAINST OBJECTS	PHYSICAL AGGRESSION AGAINST OTHER PEOPLE
<input type="checkbox"/> Slams door, scatters clothing, makes a mess <input type="checkbox"/> Slams objects down, Kicks Furniture without breaking it, marks the wall <input type="checkbox"/> Break objects, smashes window <input type="checkbox"/> Sets fires, throws objects dangerously	<input type="checkbox"/> Makes threatening gesture, swings at people, grabs at clothes <input type="checkbox"/> Strikes, Kicks, pushes, pulls hair (without injury to them) <input type="checkbox"/> Attacks others causing mild-moderate physical injury (bruises, sprain, welts) <input type="checkbox"/> Attacks others causing severe physical injury (broken bones, deep lacerations, internal injury)

Time incident began: __: __ AM/PM	Duration of incident: __: __ (hours/minutes)
-----------------------------------	--

INTERVENTION (check all that apply)

<input type="checkbox"/> None	<input type="checkbox"/> Immediate medication given by mouth	<input type="checkbox"/> Use of restraints
<input type="checkbox"/> to patient	<input type="checkbox"/> medication given by injection	<input type="checkbox"/> injury requires immediate medical treatment for patient
<input type="checkbox"/> Closer observation	<input type="checkbox"/> Isolation without seclusion (time out)	<input type="checkbox"/> requires immediate treatment for other person
<input type="checkbox"/> Holding patient	<input type="checkbox"/> Seclusion	

COMMENTS