

Overt Aggression Scale (OAS)
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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 checked="" type="checkbox"/> Makes loud noises,shouts angrily <input checked="" type="checkbox"/> Yelis mild personal insults,e.g,"you 're stupid!" <input checked="" type="checkbox"/> Cruses viciously,uses foul language in anger,makes moderate threats to others or self <input type="checkbox"/> Makes clear threats of violence loward 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 bums <input type="checkbox"/> multilates 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 checked="" type="checkbox"/> Slams door ,scatters clothing,makes a mess <input checked="" type="checkbox"/> Slams objects down ,Kicks Fumiture without breaking it ,marks the wall <input type="checkbox"/> Break objects,smashes window <input type="checkbox"/> Sets fires ,throws objects dangerously	<input checked="" type="checkbox"/> Makes threatening gesture,swings at people,grabs at clothes <input checked="" 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)
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INTERVENTION (check all that apply)

<input checked="" type="checkbox"/> None	<input checked="" type="checkbox"/> Immediate medication given by mouth	<input checked="" type="checkbox"/> Use of restraints
<input checked="" type="checkbox"/> to patient	<input checked="" type="checkbox"/> medication given by injection	<input type="checkbox"/> injury requires immediate medical treatment for patient
<input checked="" 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