Skin Picking Impact Scale (SPIS)

Name: _____

Date: _____

INSTRUCTIONS: Make a check mark next to any statements which you have found to be true for you. For true statements, please indicate degree of severity (0-5) over the PRECEDING WEEK.

	None		Mild		Severe	
1. I don't look people in the eye because of my skin picking.	0	1	2	3	4	5
2. I think my social life would be better if I didn't pick my skin.	0	1	2	3	4	5
3. I hate the way I look because of my skin picking.	0	1	2	3	4	5
4. It takes me longer to go out because of my skin picking.	0	1	2	3	4	5
5. I feel embarrassed because of my skin picking.	0	1	2	3	4	5
6. There are some things I can't do because of my skin picking.	0	1	2	3	4	5
7. I feel unattractive because of my skin picking.	0	1	2	3	4	5
8. It takes me longer than others to get ready in the morning because of my skin picking.	0	1	2	3	4	5
9. I don't like people looking at me because of my skin picking.	0	1	2	3	4	5
10. My relationships have suffered because of my skin picking.	0	1	2	3	4	5