WHIPLASH DISABILITY QUESTIONNAIRE

This questionnaire has been designed to provide information on the impact that your whiplash injury and symptoms have upon your lifestyle. Please circle the number in each section to indicate how you have been affected by the whiplash injury and symptoms. If one or more questions are not relevant to you, please leave that section blank.

DATE: _____ **Name** _____

1. How much **pain** do you have today?

0 1 2 3 4 5 6 7 8 9 10
No pain — Worst pain imaginable

2. How much do your whiplash symptoms interfere with your **personal care** (washing, dressing, etc)?

0 1 2 3 4 5 6 7 8 9 10
Not at all — Unable to perform

3. How much do your whiplash symptoms interfere with your **work/home/study duties**?

0 1 2 3 4 5 6 7 8 9 10
Not at all — Unable to perform

4. How much have your whiplash symptoms interfered with **driving or using public transport**?

0 1 2 3 4 5 6 7 8 9 10
Not at all — Unable to travel in car/use public tranport

5. How much do your whiplash symptoms interfere with **sleep**?

0 1 2 3 4 5 6 7 8 9 10
Not at all — Cannot sleep

6. How often do you experience **tiredness/fatigue** as a result of your whiplash injury/symptoms?

0 1 2 3 4 5 6 7 8 9 10
Not at all — Always

7. How much do your whiplash symptoms interfere with **social activity**?

0 1 2 3 4 5 6 7 8 9 10
Not at all — Unable to socialize

8. How much do your whiplash symptoms interfere with **sporting activity**?

0 1 2 3 4 5 6 7 8 9 10
Not at all — Unable to participate

9. How much do your whiplash symptoms interfere with **non-sporting leisure activity**?

0 1 2 3 4 5 6 7 8 9 10
Not at all — Unable to participate

10. How often do you experience **sadness/depression** as a result of your whiplash injury/symptoms?

0	1	2	3	4	5	6	7	8	9	10
Not at all										Always

11. How often do you experience **anger** as a result of your whiplash injury/symptoms?

0	1	2	3	4	5	6	7	8	9	10
Not at all										Always

12. How often do you experience **anxiety** as a result of your whiplash injury/symptoms?

0	1	2	3	4	5	6	7	8	9	10
Not at all										Always

13. How much difficulty do you have **concentrating** as a result of your whiplash injury/symptoms?

0	1	2	3	4	5	6	7	8	9	10
No difficulty										Unable to concentrate

14. How has your condition **changed** over the past month?

-5	-4	-3	-2	-1	0	1	2	3	4	5
Very much worse					No change					Very much better