

Whiplash Disability Questionnaire

FAX (800) 599-8350

Patient Last Name	Patient First Name	Patient ID	Date of Birth (MM/DD/YYYY) ____/____/____
Provider Last Name	Provider First Name	Provider Phone (area code first)	

Instructions: This questionnaire has been designed to provide information on the impact that your whiplash injury and symptoms have upon your lifestyle. Please circle a 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.

1. How much pain do you have today?

No pain Worst pain Imaginable

0 1 2 3 4 5 6 7 8 9 10

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

Not at all Unable to perform

0 1 2 3 4 5 6 7 8 9 10

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

Not at all Unable to perform

0 1 2 3 4 5 6 7 8 9 10

4. How much do your whiplash symptoms interfere with **driving or using public transport**?

Not at all Unable to travel in car/use public transport

0 1 2 3 4 5 6 7 8 9 10

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

Not at all Cannot sleep

0 1 2 3 4 5 6 7 8 9 10

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

Not at all Always

0 1 2 3 4 5 6 7 8 9 10

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

Not at all Unable to socialize

0 1 2 3 4 5 6 7 8 9 10

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

Not at all Unable to participate

0 1 2 3 4 5 6 7 8 9 10

Please turn the page

Whiplash Disability Questionnaire (Continued)

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

Not at all Unable to participate

0 1 2 3 4 5 6 7 8 9 10

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

Not at all Always

0 1 2 3 4 5 6 7 8 9 10

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

Not at all Always

0 1 2 3 4 5 6 7 8 9 10

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

Not at all Always

0 1 2 3 4 5 6 7 8 9 10

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

No difficulty Unable to concentrate

0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS: _____

I understand that the information I have provided above is current and complete to the best of my knowledge.

Signature _____ Date _____

For Office Use

Add the scores from each section. Total: _____

Minimum Detectable Change (90% confidence) is 15 Points

Source: Pinefold et al (2004). Validity and internal consistency of a Whiplash-Specific disability measure. Spine 29 (3): 263-268.

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