Name:_____ Record #:_____
Address:_____ Telephone#:_____

WHIPLASH-ASSOCIATED DISORDERS (WAD)
Minimum data/Initial visit (FORM A)

Completed by patient or with assistance

Check the appropriate answer or write answers where applicable

A. General Information

1. Today's date: Day____ Month____ Year_____

2. Date of birth: Day____ Month____ Year_____

3. Gender: ____Male ____Female

4. Height: _____

5. Weight: _____

6. Marital status:
___ Married, cohabiting
___ Formerly married
___ Never married

7. Number of dependants:_____
(Children and others)

8. Education level:
___ Grade 8 or less
___ Partial high school
___ High school graduate
___ Post-secondary, CEGEP or some university
___ University graduate

9. Combined annual family income:
___ $0 - $20,000
___ $20,001 - $40,000
___ $40,001 - $60,000
___ above $60,000

10. Employment status:
___ Paid full-time
___ Paid part-time
___ Homemaker
___ Student
___ Unemployed
___ Retired
___ Other

11. Main work activity:
____ Heavy labor
____ Light labor
____ Mostly sitting at a desk
____ Mostly standing
____ Mostly walking or moving about
____ Driving or operating a vehicle

B. Collision Information

12. Collision date: Day____Month____Year____

13. Did the collision occur in the course of your work?
____ Yes
____ No

14. Were you?
____Occupant of car or van
____ Occupant of a bus
____ On a bicycle
____ On a motorcycle
____ Pedestrian
____ Do not know

If occupant of car, van or bus, answer following questions; otherwise skip to question 21.

15. From which direction was the main impact to your vehicle?
____ Front
____ Rear
____ Driver's side
____ Passenger's side
____ Do not know

16. Did your vehicle roll over?
____ No
____ Yes
____ Do not know

QUEBECK TASK FORCE ON WHIPLASH-ASSOCIATED DISORDERS

Name:_____ Record#:_____

17. Was the vehicle drivable after the accident?
____ No
____ Yes
____ Do not know

18. Circle the place where you were seated during the collision.

Front left (driver)	Front Center	Front right (passenger)
Middle Left	Middle Center	Middle Right
Rear Left	Rear Middle	Rear Right

19. Was your seat belt fastened?
____ No
____ Yes, lap only
____ Yes, shoulder only
____ Yes, lap and shoulder only
____ Not applicable
____ Do not know

20. Was there a headrest on your seat?
____ No
____ Yes, fixed
____ Yes, adjustable
____ Yes, type unknown
____ Not applicable
____ Do not know

C. General health before collision

21. How was your health before this collision?
____ Excellent
____ Very good
____ Fair
____ Poor

22. How often did you have any of the following before this collision?

	Never or almost never	Some-times	Often	Always or almost always
Headache	☐	☐	☐	☐
Ache/pain in lower back	☐	☐	☐	☐
Ache/pain in neck/shoulder	☐	☐	☐	☐
Ache/pain in jaw	☐	☐	☐	☐

23. Have you been injured in a motor vehicle collision in the past?
____ No
____ Yes
____ Do not know

If yes, which part(s) of the body was injured
____ Head/face
____ Neck/shoulder(s)
____ Back
____ Arms(s)
____ Leg(s)
____ Other
____ Do not know

D. Post-collision symptoms

24. Did you lose consciousness?
____ No
____ Yes
____ Do not know

25. Did you hit your head?
____ No
____ Yes
____ Do not know

26. Did you break any bones?
____ No
____ Yes
____ Do not know

QUEBECK TASK FORCE ON WHIPLASH-ASSOCIATION DISORDERS

Name:_____Record #:_____

27. Have you ever felt the following symptoms since this collision? Please check the appropriate box(es).

Symptoms	Present		Beginning of symptoms				If you have the symptom, how severe is it?			
	No	Yes	Day of collision	Day after to fourth day	Later than fourth day	Do not know	Mild	Moderate	Severe	Unbearable
Neck/shoulder pain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Reduced/painful neck movements	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Headache	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Reduced/painful jaw movement	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Numbness, tingling, or pain in arm or hand	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Dizziness/unsteadiness	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Nausea/vomiting	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Difficulty swallowing	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ringing in the ears	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Memory problems	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Problems concentrating	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Vision problems	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Lower back pain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐