This questionnaire is designed to help us understand the experiences of people who have whiplash injury. It consists of 93 questions divided into 6 sections. Feel free to take a break part way through completing it and come back to the questionnaire later. All we ask is that you complete all parts of the questionnaire within 24 hours of starting it.

What was the date of your accident? _____ _____ _____
Day Month Year

Part 1: The answers to these questions will tell us about your accident.

PLEASE ANSWER THE FOLLOWING QUESTIONS BY PUTTING A CHECK IN THE APPROPRIATE BOX			
1. Was there another person **in the vehicle with you** who was injured during the accident?	☐ Yes	☐ No	☐ Don't know
2. Was there a person **in another vehicle** who was injured during the accident?	☐ Yes	☐ No	☐ Don't know
3. Did you lose consciousness during the accident?	☐ Yes	☐ No	☐ Don't know
4. Did you experience uncontrollable shaking or trembling shortly after the accident?	☐ Yes	☐ No	☐ Don't know
5. Are you able to remember the events during and immediately after the accident?	☐ Yes	☐ No	☐ Don't know
6. At any time during or immediately after the accident, did you feel that your life was threatened?	☐ Yes	☐ No	☐ Don't know
7. Have you hired a lawyer for matters related to the accident?	☐ Yes	☐ No	
8. Have you ever been injured in a car accident prior to this one?	☐ Yes	☐ No	

Part 2: These questions ask for your personal opinions and feelings about whiplash injury. There are no right or wrong answers.

PLEASE CIRCLE THE RESPONSE THAT BEST REPRESENTS THE EXTENT TO WHICH YOU AGREE WITH EACH STATEMENT.	**STRONGLY DISAGREE**	**SOMEWHAT DISAGREE**	**SOMEWHAT AGREE**	**STRONGLY AGREE**
1. I am the one best suited to control my own pain.	0	1	2	3
2. Whiplash tends to have long-term effects on health and well-being.	0	1	2	3
3. In order for whiplash to heal, someone must fix something in my neck.	0	1	2	3
4. People should be completely healed from a whiplash injury before returning to the type of activity that I usually do.	0	1	2	3
5. The weather affects my pain.	0	1	2	3
6. I feel afraid of injuring myself further.	0	1	2	3
7. I feel that I am a disabled person since my injury.	0	1	2	3
8. I feel as if my neck is fragile.	0	1	2	3
9. I am not interested in doing things I used to enjoy.	0	1	2	3
10. I have lost interest in my appearance.	0	1	2	3
11. I cannot relax when I am in a vehicle.	0	1	2	3
12. I feel as though I shouldn't be having fun.	0	1	2	3
13. I am frustrated by my inability to control my pain.	0	1	2	3
14. This injury is the worst thing that has ever happened to me.	0	1	2	3

(Continued on next page)…

PART 2 (CONTINUED) PLEASE CIRCLE THE RESPONSE THAT BEST REPRESENTS THE EXTENT TO WHICH YOU AGREE WITH EACH STATEMENT.	**STRONGLY DISAGREE**	**SOMEWHAT DISAGREE**	**SOMEWHAT AGREE**	**STRONGLY AGREE**
15. I feel as though I should not have survived the accident.	0	1	2	3
16. I feel angry at other people for not understanding what I am going through.	0	1	2	3
17. Moving my neck around makes my pain worse.	0	1	2	3
18. I find it difficult or impossible to do the things that I enjoy.	0	1	2	3

Part 3: Your answers to these questions will help us understand YOUR experiences since your whiplash injury. Please indicate how often, if ever, you have been bothered by each of the following symptoms SINCE YOUR WHIPLASH INJURY. Please circle the most appropriate answer.

RATE THE EXTENT TO WHICH YOU HAVE BEEN BOTHERED BY THE FOLLOWING SYMPTOMS SINCE YOUR ACCIDENT:	**Never**	**Rarely** (less than half of the time)	**Often** (half of the time or more)	**All of the time**
1. Dizziness	0	1	2	3
2. Headaches	0	1	2	3
3. New or increased stomach problems such as nausea, heartburn or diarrhea	0	1	2	3
4. Feelings of sadness	0	1	2	3
5. Numbness or tingling in your face or head	0	1	2	3
6. Pain, tenderness or a feeling of 'fluid' inside one or both ears	0	1	2	3
7. A general feeling of being stiff and sore throughout your muscles	0	1	2	3
8. Pain that extends beyond your shoulder and into your arm or hand	0	1	2	3
9. A sense of guilt	0	1	2	3
10. Numbness or tingling anywhere in one or both arms	0	1	2	3
11. A feeling of weakness or clumsiness in one or both arms	0	1	2	3
12. Anger or impatience with your injury	0	1	2	3
13. Stiffness in your neck	0	1	2	3
14. Pain in your neck	0	1	2	3
15. A sense of worry	0	1	2	3
16. Difficulty getting your eyes to focus on things	0	1	2	3

(Continued on next page)…

Part 3 (Continued) RATE THE EXTENT TO WHICH YOU HAVE BEEN BOTHERED BY THE FOLLOWING SYMPTOMS SINCE YOUR ACCIDENT:	**Never**	**Rarely** (less than half of the time)	**Often** (half of the time or more)	**All of the time**
17. Difficulty maintaining your concentration	0	1	2	3
18. Problems falling asleep or staying asleep	0	1	2	3
19. Difficulty when yawning or chewing food	0	1	2	3
20. Nervousness, anxiety or a feeling of being 'on edge'	0	1	2	3
21. Pain that seems to get worse or better for no reason at all	0	1	2	3
22. Stress	0	1	2	3
23. Difficulty swallowing	0	1	2	3
24. Nightmares	0	1	2	3
25. Difficulty thinking about anything other than the pain	0	1	2	3
26. Poor memory	0	1	2	3
27. Difficulty getting out of bed in the morning	0	1	2	3
28. Loss of your normal level of energy	0	1	2	3
29. A feeling of being overwhelmed by the pain	0	1	2	3
30. Flashbacks of the accident that feel very real	0	1	2	3
31. Grinding your teeth (when asleep or awake)	0	1	2	3
32. Pain in your upper or lower back	0	1	2	3
33. Difficulty relaxing your muscles	0	1	2	3

Part 4: Your answers to these questions will help us understand what strategies, if any, are helpful to YOU in managing your injury. Please indicate how often, if at all, you have used the following strategies to help you deal with your injury.

SINCE YOUR ACCIDENT, HOW MANY DAYS PER WEEK HAVE YOU	**NEVER**	**RARELY** (2 OR FEWER DAYS PER WEEK)	**OFTEN** (3 TO 6 DAYS PER WEEK)	**EVERY DAY**
1. Slept or rested outside of your normal routine (for example, slept during the day when you normally only sleep at night)?	0	1	2	3
2. Got support from a close friend or family member?	0	1	2	3
3. Completed an exercise routine or movement that increased your pain?	0	1	2	3
4. Moved your neck as far as you could in each direction?	0	1	2	3
5. Ignored your pain and carried on with your activities?	0	1	2	3
6. Taken the day off work, school or from doing housework?	0	1	2	3
7. Worn a soft collar to support your neck?	0	1	2	3
8. Taken medication to reduce inflammation?	0	1	2	3
9. Asked a friend or family member to do something that you would normally have done yourself?	0	1	2	3

Part 5: Your answers to these questions will help us understand a little about your life and health prior to your accident. Please read the questions and respond with the MOST APPROPRIATE answer.

DO YOU HAVE EITHER OF THE FOLLOWING CONDITIONS?	I DO NOT HAVE THE CONDITION	I HAVE BEEN TOLD THAT I AM AT RISK FOR THE CONDITION AND SHOULD MODIFY MY LIFESTYLE	I HAVE THE CONDITION, AM TAKING MEDICATION FOR IT, AND IT IS WELL CONTROLLED	I HAVE THE CONDITION, AM TAKING MEDICATION FOR IT, BUT IT IS NOT WELL CONTROLLED
1. Diabetes (any type)	0	1	2	3
2. Hyperlipidemia or High Cholesterol	0	1	2	3

3. Which statement regarding smoking best describes you?	☐ I have never smoked	☐ I used to smoke, but quit _____ years ago. I had smoked for _____ years.	☐ I currently smoke. I have smoked for _____ years.

Please answer the following questions using the key provided.

IN THE THREE MONTHS BEFORE THE ACCIDENT, HAD YOU	**NEVER**	**RARELY** (2 OR FEWER TIMES PER WEEK)	**OFTEN** (3-6 TIMES PER WEEK)	**EVERY DAY**
4. Performed exercise or conditioning for health or recreation?	0	1	2	3
5. Eaten breakfast to start your day?	0	1	2	3
6. Eaten 'junk' food?	0	1	2	3
7. Had emotional outbursts that you regretted later?	0	1	2	3
8. Experienced bouts of anxiety or panic that prevented you from doing something?	0	1	2	3
9. Felt bothered by the amount of stress in your life?	0	1	2	3
10. Felt sad or depressed for most of the day?	0	1	2	3
11. Been bothered by pain anywhere in your body that didn't go away or that kept coming back?	0	1	2	3

(Continued on next page)…

PART 5 (CONTINUED) IN THE THREE MONTHS BEFORE THE ACCIDENT, HAD YOU	**NEVER**	**RARELY** (2 OR FEWER TIMES PER WEEK)	**MOST DAYS** (3-6 TIMES PER WEEK)	**EVERY DAY**
12. Been bothered by neck pain?	0	1	2	3
13. Been bothered by headaches?	0	1	2	3
14. Lost time from work or school for health-related reasons?	0	1	2	3

Part 6: Please tell us a little about yourself by answering the following questions.

1. What is your biologic sex?	☐Female	☐Male		
2. In what year were you born? Year:		☐Not sure		
3. Which hand is your dominant hand?	☐Right	☐Left	☐Both	
4. At the time of your accident, how would you describe your connections with the employment market?	☐Employed full-time (for pay)	☐Employed part-time (for pay)	☐Employed but off work (i.e. due to injury/illness/ disability, or temporary leave)	☐Not employed for pay
5. What is your marital status?	☐Single	☐Married/ common-law	☐Divorced	☐Widowed
6. Were you pregnant at the time of the accident?	☐No	☐Yes	☐Not sure	☐Not applicable
7. Is <u>your</u> job the primary source of income for your family?	☐No	☐Yes	☐Not sure	☐Not applicable
8. Do you have children that are dependent on you for their well-being (i.e. through financial support or by providing food, shelter or basic care)?	☐No	☐Yes		
9. Have any of your immediate family members (parents, siblings or children) ever had a problem with chronic pain?	☐No	☐Yes	☐Not sure	
10. This list includes types of treatment that some people receive after whiplash injury. Place a check (√) beside up to TWO of these types of treatment that you would MOST like to receive if given the choice. <u>Choose no more than TWO</u>.	☐Physiotherapy ☐Acupuncture ☐Medication from your family doctor ☐Injections into a muscle or joint from a specialist ☐Exercise therapy or 'work hardening' from someone other than a physiotherapist (such as a kinesiologist or athletic trainer)		☐Chiropractic ☐Massage therapy ☐Naturopathic/homeopathic remedies ☐Psychotherapy/Counseling ☐Painkillers from a specialist ☐Other:_____ ☐No treatment	
11. Please rate the average intensity of your pain over the past 2 days (circle the number) 0 1 2 3 4 5 6 7 8 9 10 No pain Terrible pain				

Part 7:
Think about how the pain you have experienced as a result of your accident has felt over the last week. Please tick (√) the descriptions that best match your pain. These descriptions may, or may not, match your pain, no matter how severe it feels.

1. In the area where you have pain, do you also have 'pin and needles', tingling or prickling sensations?	□NO I don't get the sensation	□YES I do get these sensations
2. Does the painful area change colour (perhaps looks mottled or more red) when the pain is particularly bad?	□NO The pain does not affect the colour of my skin	□YES I have noticed that the pain does make my skin different from normal
3. Does your pain make the affected skin abnormally sensitive to touch? Getting unpleasant sensations or pain when lightly stroking the skin might describe this.	□NO The pain does not make my skin in that area abnormally sensitive to touch	□YES My skin in that area is particularly sensitive to touch
4. Does your pain come on suddenly and in bursts for no apparent reason when you are completely still? Words like 'electric shocks', jumping and bursting might describe this.	□NO My pain doesn't really feel like this	□YES I get these sensations often
5. In the area where you have pain, does your skin feel unusually hot like a burning pain?	□NO I don't have burning pain	□YES I get these sensations often
6. Gently <u>rub</u> the painful area with your index finger and then rub a non-painful area (for example the skin further away from the area, or on the opposite side). How does this rubbing feel in the painful area?	□The pain area feels no different from the non-painful area	□I feel discomfort, like pins and needles, tingling or burning in the painful area that is different from the non-painful area
7. Gently <u>press</u> on the painful area with your finger then gently press in the same way onto a non-painful area like you did in the last question. How does this feel in the painful area?	□The pain area feels no different from the non-painful area.	□I feel numbness or tenderness in the painful area that is different from the non-painful area