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	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐