**Wheelchair Skills Test Questionnaire (WST-Q), Version 4.3 for Powered Wheelchairs Operated by Their Users**

| Question | Answer |
|---|---|
| Name of the wheelchair user? | |
| Date questionnaire completed (month, day, year)? | |
| Did you complete the questionnaire yourself? | □ Yes<br>□ No |
| If you had help, what is the name of the person who helped you? | |
| If you had help, what is the relationship between you and the person who helped you? | □ Family member<br>□ Friend<br>□ Caregiver<br>□ Other person |

**Introduction to the questionnaire**

- Copies of this questionnaire can be downloaded from www.wheelchairskillsprogram.ca/eng/wstq.php.
- More details about the questionnaire can be found there in the WSP Manual.
- In this questionnaire, you will be asked questions about different skills that you might do in your wheelchair. These skills range from ones that are more basic at the beginning to those that are more advanced at the end.
- There are no "right" or "wrong" answers. The purpose of the questionnaire is simply to help us understand how you use your wheelchair.
- It will probably take about 10 minutes to complete the questionnaire, but please take as much time as you need.
- If you have more than one wheelchair, the questions are about the wheelchair that you use most often.
- If you have any comments, you will be able to record them at the end of the questionnaire.
- For each specific skill, beginning on page 3, you will be asked up to four questions. The questions and the possible answers are shown below.

- For each skill, you should answer the following question:

| **Question:** "Can you do it?" | |
|---|---|
| **Possible Answers** | **What This Means** |
| Yes | I can safely do the skill, by myself, without any difficulty. |
| Yes with difficulty | Yes, but not as well as I would like. |
| No | I have never done the skill or I do not feel that I could do it right now. |
| Not possible with this wheelchair | My wheelchair does not have the parts to allow this skill. (This option is only presented for skills where such a score is a possibility.) |

- If one of the purposes of this questionnaire is to assess how confident you are in performing the skill, you should also answer the following question for each skill:

| **Confidence question:** "How confident are you?" | |
|---|---|
| **Possible Answers** | **What this means** |
| Fully confident | As of now, I am fully confident that I can do this skill safely and consistently. |
| Somewhat confident | As of now, I am somewhat confident that I can do this skill safely and consistently. |
| Not at all confident | As of now, I am not at all confident that I can do this skill safely and consistently. |
| Not possible with this wheelchair | My wheelchair does not have the parts to allow this skill. (This option is only presented for skills where such a score is a possibility.) |

- If one of the purposes of this questionnaire is to assess how often you do the skill, you should also answer the following question for each skill:

| **Question:** "How often do you do it?" | |
|---|---|
| **Possible Answers** | **What This Means** |
| Daily | Generally, at least once a day. |
| Weekly | Generally, at least once a week. |
| Monthly | Generally, at least once a month. |
| Yearly | Generally, at least once a year. |
| Never | Generally, less often than once a year or never. |

- If one of the purposes of this questionnaire is to identify goals for training, you should also answer the following question about each skill:

| **Question:** "Is this a training goal?" | |
|---|---|
| **Possible Answers** | **What This Means** |
| Yes | I am interested in receiving training for this skill. |
| No | I am not interested in receiving training for this skill. |

- If you have training goals that you can think of now, please record them in the space available below. You will have a chance to identify other goals later.

| |
|---|
| |

- Please read the questions about specific skills that begin on the next page. For each skill, record the answers in the spaces provided.

## Questions on Specific Skills

| # | Skill Description | Questions (Pick only one answer for each question) | | | |
|---|---|---|---|---|---|
| | | **Can you do it?** | **How confident are you?** | **How often do you do it?** | **Is this a training goal?** |
| 1 | Moving the controller away and back again. | □ Yes<br>□ Yes with difficulty<br>□ No<br>□ Not possible with this wheelchair | □ Fully<br>□ Somewhat<br>□ Not at all | □ Daily<br>□ Weekly<br>□ Monthly<br>□ Yearly<br>□ Never | □ Yes<br>□ No |
| 2 | Turning the power for the wheelchair on and off. | □ Yes<br>□ Yes with difficulty<br>□ No | □ Fully<br>□ Somewhat<br>□ Not at all | □ Daily<br>□ Weekly<br>□ Monthly<br>□ Yearly<br>□ Never | □ Yes<br>□ No |
| 3 | Changing the settings and speeds for the wheelchair. | □ Yes<br>□ Yes with difficulty<br>□ No<br>□ Not possible with this wheelchair | □ Fully<br>□ Somewhat<br>□ Not at all | □ Daily<br>□ Weekly<br>□ Monthly<br>□ Yearly<br>□ Never | □ Yes<br>□ No |
| 4 | Operating all of the positioning options of the wheelchair (for example tilting the seat, reclining the seat, elevating the leg-rests). | □ Yes<br>□ Yes with difficulty<br>□ No<br>□ Not possible with this wheelchair | □ Fully<br>□ Somewhat<br>□ Not at all | □ Daily<br>□ Weekly<br>□ Monthly<br>□ Yearly<br>□ Never | □ Yes<br>□ No |
| 5 | Disengaging the motors of the wheelchair, so that it can be pushed without power, and then engaging the motors again. | □ Yes<br>□ Yes with difficulty<br>□ No | □ Fully<br>□ Somewhat<br>□ Not at all | □ Daily<br>□ Weekly<br>□ Monthly<br>□ Yearly<br>□ Never | □ Yes<br>□ No |
| 6 | Charging the battery for the wheelchair. | □ Yes<br>□ Yes with difficulty<br>□ No | □ Fully<br>□ Somewhat<br>□ Not at all | □ Daily<br>□ Weekly<br>□ Monthly<br>□ Yearly<br>□ Never | □ Yes<br>□ No |
| 7 | Moving the wheelchair straight forwards for a short distance, for example along a short hallway. | □ Yes<br>□ Yes with difficulty<br>□ No | □ Fully<br>□ Somewhat<br>□ Not at all | □ Daily<br>□ Weekly<br>□ Monthly<br>□ Yearly<br>□ Never | □ Yes<br>□ No |
| 8 | Moving the wheelchair straight backwards for a short distance, for example to back away from a table. | □ Yes<br>□ Yes with difficulty<br>□ No | □ Fully<br>□ Somewhat<br>□ Not at all | □ Daily<br>□ Weekly<br>□ Monthly<br>□ Yearly<br>□ Never | □ Yes<br>□ No |

| # | Skill Description | Questions (Pick only one answer for each question) | | | |
|---|---|---|---|---|---|
| | | **Can you do it?** | **How confident are you?** | **How often do you do it?** | **Is this a training goal?** |
| 9 | Turning the wheelchair around in a small space so that it is facing in the opposite direction. | □ Yes<br>□ Yes with difficulty<br>□ No | □ Fully<br>□ Somewhat<br>□ Not at all | □ Daily<br>□ Weekly<br>□ Monthly<br>□ Yearly<br>□ Never | □ Yes<br>□ No |
| 10 | Turning the wheelchair around a corner while moving forwards. | □ Yes<br>□ Yes with difficulty<br>□ No | □ Fully<br>□ Somewhat<br>□ Not at all | □ Daily<br>□ Weekly<br>□ Monthly<br>□ Yearly<br>□ Never | □ Yes<br>□ No |
| 11 | Turning the wheelchair around a corner while moving backwards. | □ Yes<br>□ Yes with difficulty<br>□ No | □ Fully<br>□ Somewhat<br>□ Not at all | □ Daily<br>□ Weekly<br>□ Monthly<br>□ Yearly<br>□ Never | □ Yes<br>□ No |
| 12 | Moving the wheelchair sideways in a small space, for example to get the side of your wheelchair next to a kitchen counter, and then back to where you started. | □ Yes<br>□ Yes with difficulty<br>□ No | □ Fully<br>□ Somewhat<br>□ Not at all | □ Daily<br>□ Weekly<br>□ Monthly<br>□ Yearly<br>□ Never | □ Yes<br>□ No |
| 13 | Moving the wheelchair to reach up for something overhead, for example a high elevator button. | □ Yes<br>□ Yes with difficulty<br>□ No | □ Fully<br>□ Somewhat<br>□ Not at all | □ Daily<br>□ Weekly<br>□ Monthly<br>□ Yearly<br>□ Never | □ Yes<br>□ No |
| 14 | Moving the wheelchair to pick up a small object, for example a paperback book, from the floor in front of you. | □ Yes<br>□ Yes with difficulty<br>□ No | □ Fully<br>□ Somewhat<br>□ Not at all | □ Daily<br>□ Weekly<br>□ Monthly<br>□ Yearly<br>□ Never | □ Yes<br>□ No |
| 15 | Removing the weight from your buttocks, either one at a time or both together. | □ Yes<br>□ Yes with difficulty<br>□ No | □ Fully<br>□ Somewhat<br>□ Not at all | □ Daily<br>□ Weekly<br>□ Monthly<br>□ Yearly<br>□ Never | □ Yes<br>□ No |
| 16 | Transferring from the wheelchair to a bench that is about the same height as the wheelchair and then getting back into the wheelchair. | □ Yes<br>□ Yes with difficulty<br>□ No | □ Fully<br>□ Somewhat<br>□ Not at all | □ Daily<br>□ Weekly<br>□ Monthly<br>□ Yearly<br>□ Never | □ Yes<br>□ No |
| 17 | Opening a hinged door, moving the wheelchair through it and closing it | □ Yes<br>□ Yes with difficulty<br>□ No | □ Fully<br>□ Somewhat | □ Daily<br>□ Weekly<br>□ Monthly | □ Yes<br>□ No |

| # | Skill Description | Questions (Pick only one answer for each question) | | | |
|---|---|---|---|---|---|
| | | **Can you do it?** | **How confident are you?** | **How often do you do it?** | **Is this a training goal?** |
| | behind you, then coming back the other way. | | □ Not at all | □ Yearly<br>□ Never | |
| 18 | Moving the wheelchair over a longer distance, for example on a smooth surface about the length of a sport field. | □ Yes<br>□ Yes with difficulty<br>□ No | □ Fully<br>□ Somewhat<br>□ Not at all | □ Daily<br>□ Weekly<br>□ Monthly<br>□ Yearly<br>□ Never | □ Yes<br>□ No |
| 19 | While moving the wheelchair, avoiding moving people who do not notice you. | □ Yes<br>□ Yes with difficulty<br>□ No | □ Fully<br>□ Somewhat<br>□ Not at all | □ Daily<br>□ Weekly<br>□ Monthly<br>□ Yearly<br>□ Never | □ Yes<br>□ No |
| 20 | Moving the wheelchair up a slight incline, for example a standard ramp (12 times longer than it is high). | □ Yes<br>□ Yes with difficulty<br>□ No | □ Fully<br>□ Somewhat<br>□ Not at all | □ Daily<br>□ Weekly<br>□ Monthly<br>□ Yearly<br>□ Never | □ Yes<br>□ No |
| 21 | Moving the wheelchair down a slight incline. | □ Yes<br>□ Yes with difficulty<br>□ No | □ Fully<br>□ Somewhat<br>□ Not at all | □ Daily<br>□ Weekly<br>□ Monthly<br>□ Yearly<br>□ Never | □ Yes<br>□ No |
| 22 | Moving the wheelchair up a steep incline (about twice as steep as a standard ramp). | □ Yes<br>□ Yes with difficulty<br>□ No | □ Fully<br>□ Somewhat<br>□ Not at all | □ Daily<br>□ Weekly<br>□ Monthly<br>□ Yearly<br>□ Never | □ Yes<br>□ No |
| 23 | Moving the wheelchair down a steep incline. | □ Yes<br>□ Yes with difficulty<br>□ No | □ Fully<br>□ Somewhat<br>□ Not at all | □ Daily<br>□ Weekly<br>□ Monthly<br>□ Yearly<br>□ Never | □ Yes<br>□ No |
| 24 | Moving the wheelchair across a slight side-slope, for example when crossing a driveway. | □ Yes<br>□ Yes with difficulty<br>□ No | □ Fully<br>□ Somewhat<br>□ Not at all | □ Daily<br>□ Weekly<br>□ Monthly<br>□ Yearly<br>□ Never | □ Yes<br>□ No |
| 25 | Moving the wheelchair a short distance across a soft surface, for example gravel. | □ Yes<br>□ Yes with difficulty<br>□ No | □ Fully<br>□ Somewhat<br>□ Not at all | □ Daily<br>□ Weekly<br>□ Monthly<br>□ Yearly<br>□ Never | □ Yes<br>□ No |
| 26 | Getting the wheelchair over an obstacle that sticks | □ Yes<br>□ Yes with difficulty | □ Fully<br>□ Somewhat | □ Daily<br>□ Weekly | □ Yes<br>□ No |

| # | Skill Description | Questions (Pick only one answer for each question) | | | |
|---|---|---|---|---|---|
| | | **Can you do it?** | **How confident are you?** | **How often do you do it?** | **Is this a training goal?** |
| | up above the surface, for example a door threshold. | □ No | □ Not at all | □ Monthly<br>□ Yearly<br>□ Never | |
| 27 | Getting the wheelchair over a gap, for example a rut in the road that is too big to simply roll over. | □ Yes<br>□ Yes with difficulty<br>□ No | □ Fully<br>□ Somewhat<br>□ Not at all | □ Daily<br>□ Weekly<br>□ Monthly<br>□ Yearly<br>□ Never | □ Yes<br>□ No |
| 28 | Getting the wheelchair up a low curb, for example when entering a building. | □ Yes<br>□ Yes with difficulty<br>□ No | □ Fully<br>□ Somewhat<br>□ Not at all | □ Daily<br>□ Weekly<br>□ Monthly<br>□ Yearly<br>□ Never | □ Yes<br>□ No |
| 29 | Getting the wheelchair down from a low curb. | □ Yes<br>□ Yes with difficulty<br>□ No | □ Fully<br>□ Somewhat<br>□ Not at all | □ Daily<br>□ Weekly<br>□ Monthly<br>□ Yearly<br>□ Never | □ Yes<br>□ No |
| 30 | Getting up from the ground into the wheelchair, for example after a fall. | □ Yes<br>□ Yes with difficulty<br>□ No | □ Fully<br>□ Somewhat<br>□ Not at all | □ Daily<br>□ Weekly<br>□ Monthly<br>□ Yearly<br>□ Never | □ Yes<br>□ No |

If you have any general comments about the questions that you have answered above, please record them in the space available below.

If you have any training goals that you have not already mentioned, please record them in the space available below.

A short report form will be created from the answers that you have given. If you would like a copy of the report form for yourself or someone else, please record in the space available below the name and address of the person to whom the report should be sent.

This is the end of the questionnaire. Thank you for completing it.