

Please answer all questions truthfully and to the best of your ability.

1. Date: \_\_\_/\_\_\_/\_\_\_      2. Name: \_\_\_\_\_  
Mo. Day Year Optional
3. Job Title: \_\_\_\_\_      4. Dept: \_\_\_\_\_
5. Shift: \_\_\_\_\_      6. Height: \_\_\_\_\_
7. Dominant Hand:    Left    Right    Either      8. Gender:    Male    Female
9. How long have you worked in your current position?  
 <3 mos.    3 mos. - 1 year    1 - 5 years    5 - 10 years    10+ years
10. How often are you mentally exhausted after work?  
 Never    Occasionally    Often    Always
11. How often are you physically exhausted after work?  
 Never    Occasionally    Often    Always
12. Have you ever had any pain or discomfort during the last year that you believe is related to your work?  
 Yes    No (If no, go to question 16)
13. If yes, please complete page 2 of the survey.
14. For each area of discomfort indicated on page 2, please describe what you think is causing or caused this discomfort.

BODY PART	PREVIOUS INJURY	POSSIBLE CAUSE OF PROBLEM
	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	

15. For each area of discomfort indicated on page 2, please record which job task(s) aggravates the discomfort.

BODY PART	WHAT AGGRAVATES THE PROBLEM

16. Do you have any suggestions to improve your job tasks or additional comments?

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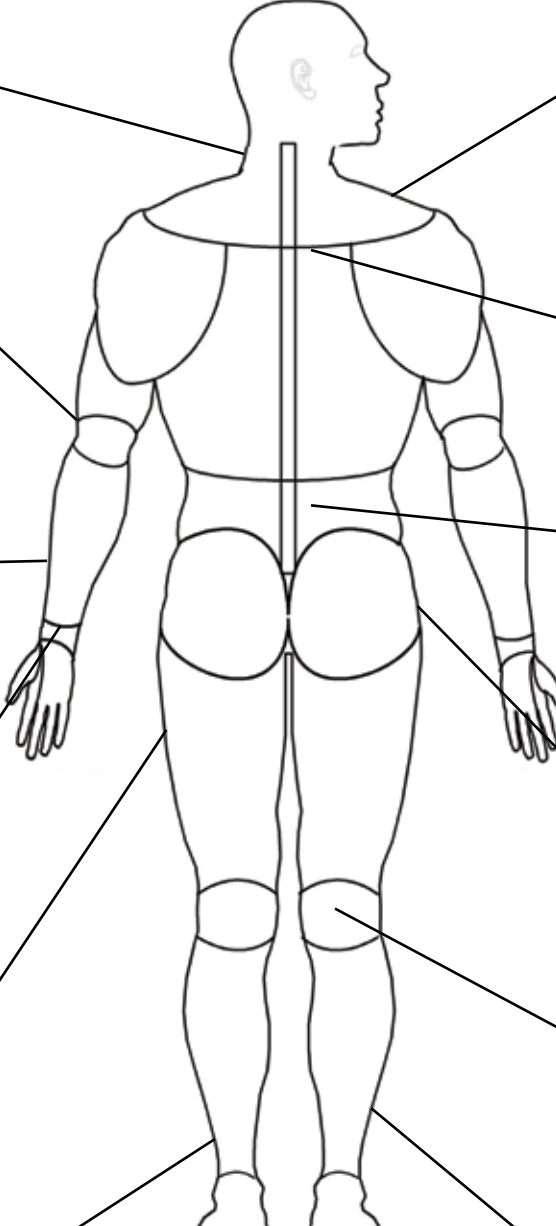


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For each body part, please indicate how often you experience pain (never, occasionally, often or always). Then indicate on a scale of 0-10 (0 being no pain and 10 being severe pain), how much pain you experience for each body part. Remember, pain includes aches, stiffness, numbness, tingling or burning sensations.



<b>NECK</b> <input type="checkbox"/> right <input type="checkbox"/> left	
<b>How often?</b> <input type="checkbox"/> Never <input type="checkbox"/> Occasionally <input type="checkbox"/> Often <input type="checkbox"/> Always	<b>How much?</b> _____

<b>SHOULDERS</b> <input type="checkbox"/> right <input type="checkbox"/> left	
<b>How often?</b> <input type="checkbox"/> Never <input type="checkbox"/> Occasionally <input type="checkbox"/> Often <input type="checkbox"/> Always	<b>How much?</b> _____

<b>ELBOWS</b> <input type="checkbox"/> right <input type="checkbox"/> left	
<b>How often?</b> <input type="checkbox"/> Never <input type="checkbox"/> Occasionally <input type="checkbox"/> Often <input type="checkbox"/> Always	<b>How much?</b> _____

<b>UPPER BACK</b> <input type="checkbox"/> right <input type="checkbox"/> left	
<b>How often?</b> <input type="checkbox"/> Never <input type="checkbox"/> Occasionally <input type="checkbox"/> Often <input type="checkbox"/> Always	<b>How much?</b> _____

<b>FOREARMS</b> <input type="checkbox"/> right <input type="checkbox"/> left	
<b>How often?</b> <input type="checkbox"/> Never <input type="checkbox"/> Occasionally <input type="checkbox"/> Often <input type="checkbox"/> Always	<b>How much?</b> _____

<b>LOWER BACK</b> <input type="checkbox"/> right <input type="checkbox"/> left	
<b>How often?</b> <input type="checkbox"/> Never <input type="checkbox"/> Occasionally <input type="checkbox"/> Often <input type="checkbox"/> Always	<b>How much?</b> _____

<b>WRIST/HANDS</b> <input type="checkbox"/> right <input type="checkbox"/> left	
<b>How often?</b> <input type="checkbox"/> Never <input type="checkbox"/> Occasionally <input type="checkbox"/> Often <input type="checkbox"/> Always	<b>How much?</b> _____

<b>HIPS</b> <input type="checkbox"/> right <input type="checkbox"/> left	
<b>How often?</b> <input type="checkbox"/> Never <input type="checkbox"/> Occasionally <input type="checkbox"/> Often <input type="checkbox"/> Always	<b>How much?</b> _____

<b>THIGHS</b> <input type="checkbox"/> right <input type="checkbox"/> left	
<b>How often?</b> <input type="checkbox"/> Never <input type="checkbox"/> Occasionally <input type="checkbox"/> Often <input type="checkbox"/> Always	<b>How much?</b> _____

<b>KNEES</b> <input type="checkbox"/> right <input type="checkbox"/> left	
<b>How often?</b> <input type="checkbox"/> Never <input type="checkbox"/> Occasionally <input type="checkbox"/> Often <input type="checkbox"/> Always	<b>How much?</b> _____

<b>ANKLES/FEET</b> <input type="checkbox"/> right <input type="checkbox"/> left	
<b>How often?</b> <input type="checkbox"/> Never <input type="checkbox"/> Occasionally <input type="checkbox"/> Often <input type="checkbox"/> Always	<b>How much?</b> _____

<b>OTHER:</b> _____	
<b>How often?</b> <input type="checkbox"/> Never <input type="checkbox"/> Occasionally <input type="checkbox"/> Often <input type="checkbox"/> Always	<b>How much?</b> _____

<b>LOWER LEGS</b> <input type="checkbox"/> right <input type="checkbox"/> left	
<b>How often?</b> <input type="checkbox"/> Never <input type="checkbox"/> Occasionally <input type="checkbox"/> Often <input type="checkbox"/> Always	<b>How much?</b> _____

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Revised: October 2011