

EMPLOYEE RISK ASSESSMENT QUESTIONNAIRE

Workplace Violence

Name: _____

Title: _____

Manager's Name: _____

Company: _____

Date Completed: _____

1. Have you experienced verbal abuse (e.g., swearing, insults, teasing, or bullying) while an employee of this company? yes no

If **yes**, did you report the incident(s)? yes no

If **yes**, how did you report the incident(s)? orally? in writing?

What was the relationship of the abuser to you?

co-worker client/customer member of the public

other (describe) _____

2. Have you experienced verbal or written threats (e.g., "If you don't get off my back, you'll regret it.") while an employee of this company? yes no

If **yes**, did you report the incident(s)? yes no

If **yes**, how did you report the incident(s)? orally? in writing?

What was the relationship of the abuser to you?

co-worker client/customer member of the public

other (describe) _____

3. Have you been threatened with physical harm (e.g., someone shaking a fist, throwing objects, committing vandalism) while an employee of this company? yes no

If **yes**, did you report the incident(s)? yes no

If **yes**, how did you report the incident(s)? orally? in writing?

What was the relationship of the abuser to you?

co-worker client/customer member of the public

other (describe) _____

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4. Have you experienced a physical assault or attack while an employee of this company?	<input type="checkbox"/> yes	<input type="checkbox"/> no
If yes , did you report the incident(s)?	<input type="checkbox"/> yes	<input type="checkbox"/> no
If yes , how did you report the incident(s)?	<input type="checkbox"/> orally?	<input type="checkbox"/> in writing?
What was the relationship of the abuser to you?		
<input type="checkbox"/> co-worker	<input type="checkbox"/> client/customer	<input type="checkbox"/> member of the public
<input type="checkbox"/> other (describe) _____		
5. Do you ever:		
– work alone or with a small number of co-workers?	<input type="checkbox"/> yes	<input type="checkbox"/> no
– work in a community-based setting?	<input type="checkbox"/> yes	<input type="checkbox"/> no
– work late at night or early in the morning?	<input type="checkbox"/> yes	<input type="checkbox"/> no
6. Are you concerned about work rage on the job?	<input type="checkbox"/> yes	<input type="checkbox"/> no
What is the source of your concern?	_____	
7. Do you believe that work rage in your workplace is a		
<input type="checkbox"/> high risk?	<input type="checkbox"/> medium risk?	<input type="checkbox"/> low risk?

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