Double Check that Checklist

Symptoms Survey: Ergonomics Program

Date ___________
Plant _____ Dept. # _____ Job Name _____
Shift _____ Hours worked/ week _____ Years _____ Month _____
(Time on THIS job)

Other jobs you have done in the last year (for more than 2 weeks)
Plant _____ Dept. # _____ Job Name _____ Months _____ Weeks _____
(Time on THIS job)

Plant _____ Dept. # _____ Job Name _____ Months _____ Weeks _____
(Time on THIS job)
(If more than 2 jobs, include those you worked on the most.)

Front

Have you had any pain or discomfort during the last year?
❑ Yes ❑ No (if NO, stop here)
if YES, carefull shade in area of the drawing which bothers you the MOST.

(Complete a separate page for each area that bothers you)
Check area ❑ Shoulder ❑ Elbow/ Forearm ❑ Neck
❑ Hand/ Wrist ❑ Fingers ❑ Ankle/ Foot
❑ Upper Back ❑ Low Back ❑ Thigh/ Knee ❑ Low Leg

Back

1. Please put a check by the word(s) that best describe your problem
❑ Aching ❑ Numbness (asleep) ❑ Tingling ❑ Loss of color
❑ Burning ❑ Pain ❑ Weakness ❑ Other
❑ Cramping ❑ Swelling ❑ Stiffness

2. When did you first notice the problem? _____ (month) _____ (year)

3. How long does each episode last? (Mark an X along the line)
1 hour / 1 day/ 1 week/ 1 month/ 6 months

4. How many seperate episodes have you had in the last year? __________

5. What do you think caused the problem? ____________________________________

6. Have you had this problem in the last 7 days? ❑ Yes ❑ No

7. How would you rate this problem? (mark an X on the line)
Now: None ______________________________________ Unbearable
When it is the WORST: None ______________________________________ Unbearable

8. Have you had medical treatment for this problem? ❑ Yes ❑ No

8a. If No, why not? ____
8b. If Yes, where did you recieve treatment?
❑ 1. Company Medical Times in past year: __________
❑ 2. Personal Doctor Times in past year: ___________
❑ 3. Other Times in past year: ___________

9. Did treatment help? ❑ Yes ❑ No

10. How many days in the last year were you on restricted or light duty because of this problem? _____ (days)
Please comment on what you think would improve your symptoms:

____

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