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.)

Have you had any pain or discomfort during the last year?
☑ Yes ☐ No (if NO, stop here)
If YES, carefully 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

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 separate 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 receive 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:
________________________________________________________________________________
________________________________________________________________________________