Discomfort Survey

Personal Information

Name:_____

1. Height: 2. Weight: 3. Gender: M ☐ F ☐

Job Information

4. Current Job Title:_____

5. Length of Time at Current Job:

- ☐ Less than 3 months
- ☐ 3 to 12 months
- ☐ More than 1 but less than 3 years
- ☐ 3 to 5 years
- ☐ More than 5 but less than 10 years
- ☐ More than 10 years

6. Other Jobs Currently Performed: How Often:

_____ _____

_____ _____

_____ _____

_____ _____

A. Less than 25% of the shift
B. 25 to 50% of the shift
C. More than 50% of the shift

7. Past/Previous Job Titles:

_____ _____

years or months at this job *years or months at this job*

_____ _____

years or months at this job *years or months at this job*

Discomfort Information

8. In the last year, have you felt any musculoskeletal discomfort or pain while performing your job?
   - ☐ Yes If Yes, please continue on the next page
   - ☐ No If No, you are now finished the questionnaire.

9. Using the scale below, rate your discomfort or pain levels by circling the appropriate number associated with each body part. Please notice that this is the feeling when you perform your job. Do this for each body part in which you feel discomfort or pain.

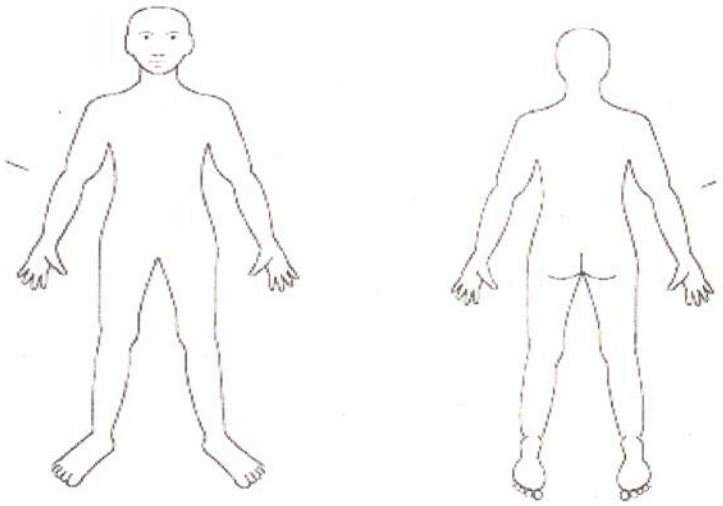
Example: For "moderate discomfort or pain" in the neck:

2	Neck	0	1	2	3	4	5

0 No Discomfort **2 Mild Discomfort** **4 Major Discomfort**
1 Minor Discomfort ***3 Moderate Discomfort*** ***5 Severe Discomfort***

1	Head/Eye	0	1	2	3	4	5	**12**	Left Hand/Finger	0	1	2	3	4	5
2	Neck	0	1	2	3	4	5	**13**	Right Hand/Finger	0	1	2	3	4	5
3	Upper Back	0	1	2	3	4	5	**14**	Low Back	0	1	2	3	4	5
4	Left Shoulder	0	1	2	3	4	5	**15**	Left Hip/Thigh	0	1	2	3	4	5
5	Right Shoulder	0	1	2	3	4	5	**16**	Right Hip/Thigh	0	1	2	3	4	5
6	Left Elbow	0	1	2	3	4	5	**17**	Left Knee	0	1	2	3	4	5
7	Right Elbow	0	1	2	3	4	5	**18**	Right Knee	0	1	2	3	4	5
8	Left Forearm	0	1	2	3	4	5	**19**	Left Ankle/Foot	0	1	2	3	4	5
9	Right Forearm	0	1	2	3	4	5	**20**	Right Ankle/Foot	0	1	2	3	4	5
10	Left Wrist	0	1	2	3	4	5		Other:	0	1	2	3	4	5
11	Right Wrist	0	1	2	3	4	5								

Shade in the areas of the body in which you feel the most pain or discomfort. For example, for neck or discomfort or pain:



10. Does your present job make your discomfort or pain worse? ☐ Yes ☐ No

If Yes, explain:_____

_____

_____

_____

11. Have you received any treatment (e.g. medication, hot/cold treatment, physiotherapy, etc.) to relieve the discomfort or pain?

☐ Yes ☐ No

If Yes, explain:_____

_____

_____

_____

12. a) Do you have any ideas what are the factors in your job (e.g. the object handled, the workstation, the work technique, tool used, etc.) causing the discomfort or pain?

_____

_____

_____

_____

b) Do you have any suggestions to improve the work condition to prevent or reduce the possibility of causing the discomfort or pain?

_____

_____

_____

_____

Thank you very much for completing this survey.

Discomfort Worksheet

Tally of reported discomfort for a worksite job title by body part.

Worksite Job Title:_____Date:_____

Number of Workers:_____ Number of Surveys Returned:_____

Number of surveys with "Yes" to discomfort/pain (question 8):_____

Body Part	Tally of Discomfort Values	Tally Totals	Number of Incidents	Average Discomfort Value
Head/Eye				
Neck				
Upper Back				
Shoulder (L)				
Shoulder (R)				
Elbow (L)				
Elbow (R)				
Forearm (L)				
Forearm (R)				
Wrist (L)				
Wrist (R)				
Hand/Finger (L)				
Hand/Finger (R)				
Low Back				
Hip/Thigh (L)				
Hip/Thigh (R)				
Knee (L)				
Knee (R)				
Ankle/Foot (L)				
Ankle/Foot (R)				
Other				
		Tally Total	Total of Incidents	

Grand Average of Discomfort Values: