**Discomfort Survey**

|  |
| --- |
| **Personal Information** |

Name:

|  |
| --- |
| **Job Information** |

1. Current Job Title:

1. 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

3. Other Jobs Currently Performed: How Often:

1. Less than 25% of the shift
2. 25 to 50% of the shift
3. More than 50% of the shift

4. 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** |

5. 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.

6. 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:*

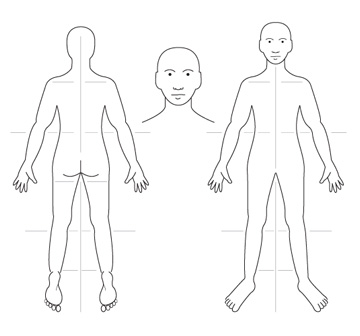
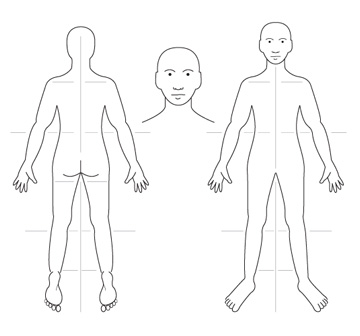
|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 2 | Neck | 0 | 1 | 2 | 3 | 4 | 5 |

#### 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:

****7. Does your present job make your discomfort or pain worse?  Yes  No

If Yes, explain:

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

Yes  No

If Yes, explain:

1. 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?

1. 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 |  |  |  |  |
| Grand Average of Discomfort Values: |  | Tally Total | Total of Incidents |  |
|  |  |  |  |  |