Ergonomics Program: Symptoms Survey

All information disclosed here will remain confidential.

|  |  |
| --- | --- |
| **Name**:  | **Date**:  |
| **Department**:  | **Position Title**:  |

1. Other jobs you have done in the last year (for more than 2 weeks):

*List Department, Position held, and Time on the Job.*

1. Have you had any pain or discomfort in the upper extremities during the last year?

 [ ]  YES [ ]  NO

If YES, carefully shade in area(s) of the drawing below where you have the MOST problems:



1. Check the area(s) below where you have pain/discomfort. If you have more than one area of problems, make additional copies of this page and complete a separate page for each area.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| [ ]  Neck | [ ]  Shoulder | [ ]  Elbow/ Forearm | [ ]  Hand/ Wrist | [ ]  Fingers |
| [ ]  Upper Back | [ ]  Lower Back | [ ]  Thigh/ Knee | [ ]  Lower Leg | [ ]  Ankle/ Foot |

1. Put a check by the words that best describe the problem.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| [ ]  Aching | [ ]  Numbness | [ ]  Tingling | [ ]  Burning | [ ]  Pain |
| [ ]  Weakness | [ ]  Cramping | [ ]  Swelling | [ ]  Stiffness | [ ]  Other:  |

1. When did you first notice the problem? *(Month/ Year)*

1. Approximately how long does each episode last?

|  |  |  |  |
| --- | --- | --- | --- |
| [ ]  1 hour | [ ]  1 day | [ ]  1 week | [ ]  6 months |

1. How many separate episodes have you had in the past year?

1. What task do you think caused the problem?

1. Have you had this problem within the past week or two?

 [ ]  YES [ ]  NO

1. How would you rate the pain/discomfort, etc. of this problem? (Mark an X on the line)

***NOW***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*None Unbearable*

***When it is the WORST***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*None Unbearable*

1. Have you had any medical treatment for this problem?

 [ ]  YES [ ]  NO

* 1. If NO, why not?

* 1. If YES, where did you receive treatment?

|  |  |
| --- | --- |
| [ ]  University Health Center | Number of times in past year:  |
| [ ]  Personal Doctor | Number of times in past year:  |
| [ ]  Other:  | Number of times in past year:  |

* + 1. Did treatment help?

 [ ]  YES [ ]  NO

1. How many workdays have you lost in the last year because of this problem?

1. How many days in the last year were you on restricted or light duty?

1. What do you think would help to improve this problem and your symptoms?

*Adapted from NIOSH's Elements of Ergonomics Programs*

*Version 5/22/2001*