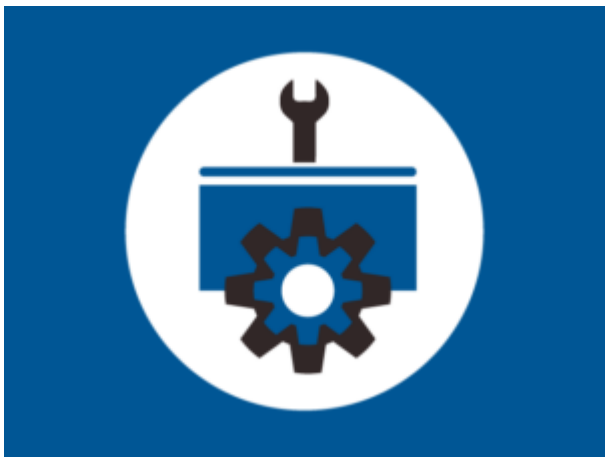
Tool: Employee MSD Symptoms Survey



EMPLOYEE MSD SYMPTOMS SURVEY

Please answer all questions truthfully and to the best of your ability.

1. Date: _____ / _____ / _____ 2. Name: _____
2. Job Title:_____
3. Department: _____ 5. Shift:_____
4. Describe the type of work you perform in this job and the amount of time each day spent on these activities.

Task
Time

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Height: _____ feet and inches, or ____ cm

Personal Information

7. Birth date: _____ (year)
8. Gender: [ ] female [ ] male
9. Which hand is your dominant hand? (please check one): [ ] left [ ] right [ ] either
10. How long have you worked in your **current** position?

[ ] Less than 3 month
[ ] 3 months to 1 year

[ ] 1 year to 5 years
[ ] 5 years to 10 years
[ ] Greater than 10 years

12. How often are you **mentally** exhausted after work?

[ ] Never [ ] Occasionally [ ] Often [ ] Always

13. How often are you **physically** exhausted after work?

[ ] Never [ ] Occasionally [ ] Often [ ] Always

14. Have you ever had any pain or discomfort during the last year that you believe is related to your work?

□ Yes □ No (If **NO**, ***stop here***)

15. If **YES**, for each body part described in the boxes on the reverse side of this page, please indicate:

[ ] How often you have discomfort in each body part

[ ] The severity of discomfort

[ ] Whether the pain interferes with your ability to do your job

[ ] On which side of the body the discomfort is felt

For each area with 'Pain' or 'Severe Pain', or in which 'Discomfort' is felt 'Always', please indicate what you think may have caused the problem, and check either 'yes' or 'no', to indicate whether you have suffered a previous injury to this body part.

BODY PART	PREVIOUS INJURY	POSSIBLE CAUSE OF PROBLEM
	[ ] Yes [ ] No	
	[ ] Yes [ ] No	
	[ ] Yes [ ] No	
	[ ] Yes [ ] No	

PHYSICAL DISCOMFORT SURVEY

Please note: "pain" may include aches, stiffness, numbness, tingling or burning sensations

ID # _____

PHYSICAL DISCOMFORT SURVEY

Please note: 'pain' may include aches, stiffness, numbness, tingling or burning sensations

NECK

How often?	How Much?
❑ Never	❑ No Discomfort
❑ Occasionally	❑ Discomfort
❑Often	❑ Pain
❑ Always	❑ Severe Pain

SHOULDERS ❑ right ❑ left

How often?	How Much?
❑ Never	❑ No Discomfort
❑ Occasionally	❑ Discomfort
❑ Often	❑ Pain
❑ Always	❑ Severe Pain

ELBOWS ❑right ❑ left

How often?	How Much?
❑ Never	❑ No Discomfort
❑ Occasionally	❑ Discomfort
❑Often	❑ Pain
❑ Always	❑ Severe Pain

UPPER BACK

How often?	How Much?
❑ Never	❑ No Discomfort
❑ Occasionally	❑ Discomfort
❑Often	❑ Pain
❑ Always	❑ Severe Pain

FOREARMS ❑right ❑left

How often?	How Much?
❑ Never	❑ No Discomfort
❑ Occasionally	❑ Discomfort
❑Often	❑ Pain
❑ Always	❑ Severe Pain

LOWER BACK ❑ right ❑ left

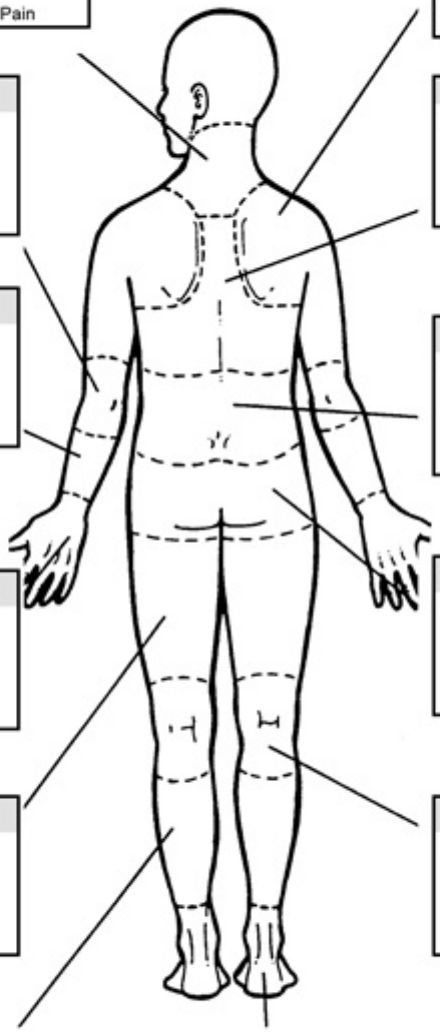
How often?	How Much?
❑ Never	❑ No Discomfort
❑ Occasionally	❑ Discomfort
❑ Often	❑ Pain
❑ Always	❑ Severe Pain

WRISTS/ HANDS ❑ right ❑left

How often?	How Much?
❑ Never	❑ No Discomfort
❑ Occasionally	❑ Discomfort
❑Often	❑ Pain
❑ Always	❑ Severe Pain

HIPS ❑ right ❑ left

How often?	How Much?
❑ Never	❑ No Discomfort
❑ Occasionally	❑ Discomfort
❑ Often	❑ Pain
❑ Always	❑ Severe Pain



THIGHS ❑ right ❑ left

How often?	How Much?
❑ Never	❑ No Discomfort
❑ Occasionally	❑ Discomfort
❑ Often	❑ Pain
❑ Always	❑ Severe Pain

KNEES ❑ right ❑ left

How often?	How Much?
❑ Never	❑ No Discomfort
❑ Occasionally	❑ Discomfort
❑ Often	❑ Pain
❑ Always	❑ Severe Pain

LOWER LEGS ❑ right ❑ left

How often?	How Much?
❑ Never	❑ No Discomfort
❑ Occasionally	❑ Discomfort
❑ Often	❑ Pain
❑ Always	❑ Severe Pain

ANKLES / FEET ❑ right ❑ left

How often?	How Much?
❑ Never	❑ No Discomfort
❑ Occasionally	❑ Discomfort
❑ Often	❑ Pain
❑ Always	❑ Severe Pain

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