| DISCOMFORT SURVEY | | | |
|---|---|---|---|
| Date: | Evaluator: | | |

| Job Information | |
|---|---|
| Name: | Years on Job: |
| Position: | |

*Rate your physical discomfort on a scale of 0 to 5, where 0 = no discomfort and 5 = moderate to severe discomfort and/or constant symptoms.*

| Body Part | Right | Left | Task(s) that usually causes discomfort |
|---|---|---|---|
| Hand/wrist | | | |
| Elbow | | | |
| Shoulder | | | |
| Neck | | | |
| Back | | | |
| Legs | | | |
| Headache/eyestrain | | | |
| Other | | | |

1. Have you sought or received medical assistance or treatment (physio/chiro/family doctor/etc.) for any of these body parts? ☐ Yes ☐ No

   If yes, please specify:

2. Have there been any changes made to your workstation or job tasks that you must perform to do your job?
   ☐ Yes ☐ No

   If yes, please specify:

*3. Do you have any suggestions that may improve your job?*