Ergonomics Symptoms Survey-Early Intervention

For Completion on site by medical provider.

Completed by ______________________________ **Date** ______________

Company/address ______________________________

Employee name/job ______________________________

Length of time performing this job/hours worked per day ______________________________

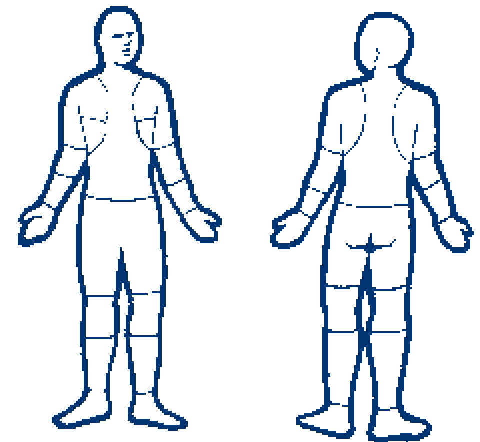
Work hardening period ______________________________ Job/task rotation ______________

Length of time at each job and muscle groups/ movements required ______________________________

Job/task requires high repetition and/or force ________ Yes ________No. Fatigue or discomfort is felt while at or away from work ______ Yes ______ No. Describe feeling ______________________________

Grade from 0-10, 0 = no discomfort or pain, 10 = extreme discomfort or pain.
Description: ache/pain, cramps, swelling, tingling, burning, numbness, stiffness or weakness.

Body Part	Right Side Grade	Left Side Grade	Description
Neck			
Shoulder			
Upper back			
Lower back			
Elbow			
Upper arm			
Forearm			
Wrist			
Hand			
Finger or thumb			
Hip or thigh			
Upper leg			
Knee			
Lower leg			
Ankle or foot			
General			



When were signs or symptoms first noticed? ______________ Have you had medical attention for them? ________

What activities do you believe caused signs or symptoms? ______________________________

Describe the equipment, tools or other aspects of the work environment ______________________________

What hobbies, work or activities do you have outside of work? ______________________________

Recommended job/task modification-exercise-first aid ______________________________

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