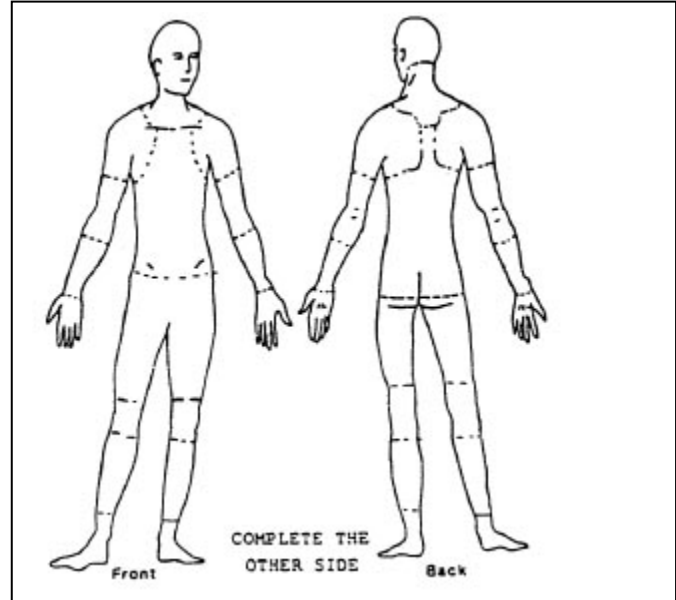




# SYMPTOMS SURVEY ERGONOMIC SCREENING

OFFICE ERGONOMICS TRAINING  
(13<sup>th</sup> March 2007)



**Check Area:**

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

**Please put a check by the word(s) that best describe your problem**

- Aching     Numbness (asleep)     Tingling     Burning     Stiffness
- Pain     Weakness     Cramping     Swelling     Other     Loss of Color

**When did you first notice the problem?**    (month)    (year)

**How long does each episode last?**

- 1 hour     1 day     1 week     1 month     6 months

**How many separate episodes have you had in the last year?**

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**What do you think caused the problem?**

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IHS Occupational Health Division

Have you had this problem in the last 7 days?  Yes  No

How would you rate this problem?

No problem  Bearable  Unbearable

Have you had medical treatment for this problem?  Yes  No

If NO, Why?

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If YES, where did you receive treatment?

Company Medical  Personal doctor  Other

If YES, did the treatment help?  Yes  No

How much time (*in days*) have you lost in the last year because of this problem?

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How many days in the last year were you on restricted or light duty because of this problem?

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Please comment on what you think would improve your symptoms:

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Name:

Age:

Job nature:

Date: