|  |
| --- |
| **Discomfort Survey** |
| Based on your average workday, please complete the ***Discomfort Survey***. Fill in all of the boxes below. Please respond honestly and thoughtfully. **Your responses are anonymous.****THANK YOU!** | **Date:** | / / |
| **Handedness:** | Right | Left | Ambidextrous |
| **Line/Work Unit:** |  |
| **Operation/Task:** |  |

**Rate discomfort** for each region by writing the number (0 to 3 in the box.)

**0=NONE/MINIMAL:** No discomfort at all. Some discomfort, able to reasonable cope with discomfort while performing general tasks

**1=MODERATE:** Moderate discomfort, some difficulty in performing general activities

**2=SEVERE:** Significant difficulty in performing general activities

**3=MAX:** Maximum discomfort (unable to function, admitted to the hospital)

|  |  |  |
| --- | --- | --- |
| **BODY PART** | **Left** | **Right** |
| **A** | **Head/Neck/Eyes** |  |  |
| **B** | **Shoulder/Upper Back** |  |  |
| **C** | **Low Back (Mid/Low)** |  |  |
| **D** | **Arms/Elbows** |  |  |
| **E** | **Hands/Wrists/Fingers** |  |  |
| **F** | **Legs/Feet** |  |  |
| **TOTAL SCORE** |  |  |

**Please respond to questions below (circle response):**

|  |  |  |
| --- | --- | --- |
| **How physically hard do you rate your work?** | **Easy** | **Moderate** |
| **Hard** | **Very Hard** |
| **How much energy do you have left at the end of your shift?** | **Lots** | **Some** |
| **Little** | **None** |

**OVER FOR ADDITIONAL COMMENTS**

Please list suggestions to make your work more comfortable, safe and productive.

# 1.

**2.**

# 3.

**4.**

# 5.