Workplace Safety North™
A Health & Safety Ontario Partner

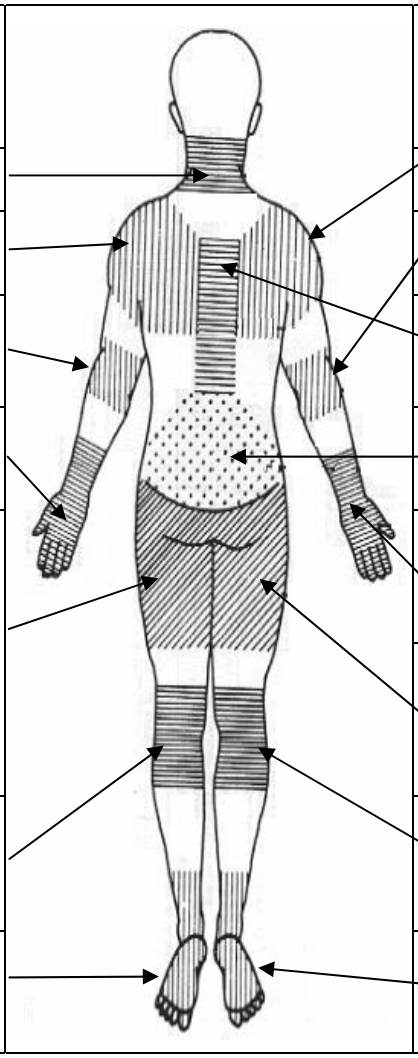
Employee Discomfort Survey

Years on this job ☐ <1 ☐ 1-2 ☐ 2-5 ☐ 5-10 ☐ 15 + yrs

1. Have you had pain or discomfort during the last year that you feel is job related?

[ ] Yes [ ] No (if NO, Stop here)

2. If YES, please rate the level of discomfort over the last MONTH by checking off the appropriate box using the scale of 0 to 10, with 0 being no discomfort and 10 being the worst discomfort ever.

No Discomfort ↓ 0 1 2 3 4 5 6 7 8 9 10 ↓ Worst Discomfort Ever			No Discomfort ↓ 0 1 2 3 4 5 6 7 8 9 10 ↓ Worst Discomfort Ever	
☐☐☐☐☐☐☐☐☐☐☐	Neck		Right Shoulder	☐☐☐☐☐☐☐☐☐☐☐
☐☐☐☐☐☐☐☐☐☐☐	Left Shoulder		Right Elbow/ Forearm	☐☐☐☐☐☐☐☐☐☐☐
☐☐☐☐☐☐☐☐☐☐☐	Left Elbow/ Forearm		Upper Back	☐☐☐☐☐☐☐☐☐☐☐
☐☐☐☐☐☐☐☐☐☐☐	Left Wrist/ Hand		Lower Back	☐☐☐☐☐☐☐☐☐☐☐
☐☐☐☐☐☐☐☐☐☐☐	Left Hip/ Thigh/ Buttock		Right Hand/ Wrist	☐☐☐☐☐☐☐☐☐☐☐
			Right Hip/ Thigh/ Buttock	☐☐☐☐☐☐☐☐☐☐☐
☐☐☐☐☐☐☐☐☐☐☐	Left Knee		Right Knee	☐☐☐☐☐☐☐☐☐☐☐
☐☐☐☐☐☐☐☐☐☐☐	Left Ankle/ Foot		Right Ankle/ Foot	☐☐☐☐☐☐☐☐☐☐☐

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3. When did you first notice your discomfort?

- ☐ within the last few weeks
- ☐ within the last few months
- ☐ within the last few years
- ☐ other_____

4. What do you think caused the discomfort?

- ☐ twisting
- ☐ lifting
- ☐ pushing
- ☐ pulling
- ☐ working too fast
- ☐ prolonged sitting
- ☐ other_____

5. Please comment on what you think would help to reduce your level of discomfort

- ☐ change job task technique
- ☐ take my rest breaks
- ☐ report the discomfort to my supervisor
- ☐ increase my fitness level
- ☐ other_____

6. Do you consider your discomfort to be a 'problem'?

☐ Yes ☐ No

7. Have you received medical treatment (doctor, chiropractor, physiotherapist, massage therapist, etc.) for your discomfort?

☐ Yes ☐ No

8. Have you taken time off work as a result of your discomfort (vacation, sick days, lost time claim, medical aid, etc.)?

☐ Yes ☐ No