

Tool: Employee MSD Symptoms Survey



EMPLOYEE MSD SYMPTOMS SURVEY

Please answer all questions truthfully and to the best of your ability.

1. Date: ____ / ____ / ____ 2. Name: _____
3. Job Title: _____
3. Department: _____ 5. Shift: _____
4. Describe the type of work you perform in this job and the amount of time each day spent on these activities.

Task Time

[illegible]

Height: _____ feet and inches, or _____ cm

Personal Information

7. Birth date: _____ (year)
8. Gender: ☐ female ☐ male
9. Which hand is your dominant hand? (please check one): ☐ left ☐ right ☐ either
10. How long have you worked in your **current** position?

- ```
[] Less than 3 month
[] 3 months to 1 year
[] 1 year to 5 years
[] 5 years to 10 years
```

☐ Greater than 10 years

12. How often are you **mentally** exhausted after work?

☐ Never ☐ Occasionally ☐ Often ☐ Always

13. How often are you **physically** exhausted after work?

☐ Never ☐ Occasionally ☐ Often ☐ Always

14. Have you ever had any pain or discomfort during the last year that you believe is related to your work?

☐ Yes ☐ No (If **NO**, **stop here**)

15. If **YES**, for each body part described in the boxes on the reverse side of this page, please indicate:

☐ How often you have discomfort in each body part

☐ The severity of discomfort

☐ Whether the pain interferes with your ability to do your job

☐ On which side of the body the discomfort is felt

For each area with 'Pain' or 'Severe Pain', or in which 'Discomfort' is felt 'Always', please indicate what you think may have caused the problem, and check either 'yes' or 'no', to indicate whether you have suffered a previous injury to this body part.

| BODY PART | PREVIOUS INJURY              |                             | POSSIBLE CAUSE OF PROBLEM |
|-----------|------------------------------|-----------------------------|---------------------------|
|           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |                           |
|           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |                           |
|           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |                           |
|           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |                           |

### PHYSICAL DISCOMFORT SURVEY

Please note: "pain" may include aches, stiffness, numbness, tingling or burning sensations

**PHYSICAL DISCOMFORT SURVEY**

Please note: 'pain' may include aches, stiffness, numbness, tingling or burning sensations

| NECK                                  |                                        |
|---------------------------------------|----------------------------------------|
| <b>How often?</b>                     | <b>How Much?</b>                       |
| <input type="checkbox"/> Never        | <input type="checkbox"/> No Discomfort |
| <input type="checkbox"/> Occasionally | <input type="checkbox"/> Discomfort    |
| <input type="checkbox"/> Often        | <input type="checkbox"/> Pain          |
| <input type="checkbox"/> Always       | <input type="checkbox"/> Severe Pain   |

| SHOULDERS                             |                                        | <input type="checkbox"/> right <input type="checkbox"/> left |
|---------------------------------------|----------------------------------------|--------------------------------------------------------------|
| <b>How often?</b>                     | <b>How Much?</b>                       |                                                              |
| <input type="checkbox"/> Never        | <input type="checkbox"/> No Discomfort |                                                              |
| <input type="checkbox"/> Occasionally | <input type="checkbox"/> Discomfort    |                                                              |
| <input type="checkbox"/> Often        | <input type="checkbox"/> Pain          |                                                              |
| <input type="checkbox"/> Always       | <input type="checkbox"/> Severe Pain   |                                                              |

| ELBOWS                                |                                        | <input type="checkbox"/> right <input type="checkbox"/> left |
|---------------------------------------|----------------------------------------|--------------------------------------------------------------|
| <b>How often?</b>                     | <b>How Much?</b>                       |                                                              |
| <input type="checkbox"/> Never        | <input type="checkbox"/> No Discomfort |                                                              |
| <input type="checkbox"/> Occasionally | <input type="checkbox"/> Discomfort    |                                                              |
| <input type="checkbox"/> Often        | <input type="checkbox"/> Pain          |                                                              |
| <input type="checkbox"/> Always       | <input type="checkbox"/> Severe Pain   |                                                              |

| UPPER BACK                            |                                        |
|---------------------------------------|----------------------------------------|
| <b>How often?</b>                     | <b>How Much?</b>                       |
| <input type="checkbox"/> Never        | <input type="checkbox"/> No Discomfort |
| <input type="checkbox"/> Occasionally | <input type="checkbox"/> Discomfort    |
| <input type="checkbox"/> Often        | <input type="checkbox"/> Pain          |
| <input type="checkbox"/> Always       | <input type="checkbox"/> Severe Pain   |

| FOREARMS                              |                                        | <input type="checkbox"/> right <input type="checkbox"/> left |
|---------------------------------------|----------------------------------------|--------------------------------------------------------------|
| <b>How often?</b>                     | <b>How Much?</b>                       |                                                              |
| <input type="checkbox"/> Never        | <input type="checkbox"/> No Discomfort |                                                              |
| <input type="checkbox"/> Occasionally | <input type="checkbox"/> Discomfort    |                                                              |
| <input type="checkbox"/> Often        | <input type="checkbox"/> Pain          |                                                              |
| <input type="checkbox"/> Always       | <input type="checkbox"/> Severe Pain   |                                                              |

| LOWER BACK                            |                                        | <input type="checkbox"/> right <input type="checkbox"/> left |
|---------------------------------------|----------------------------------------|--------------------------------------------------------------|
| <b>How often?</b>                     | <b>How Much?</b>                       |                                                              |
| <input type="checkbox"/> Never        | <input type="checkbox"/> No Discomfort |                                                              |
| <input type="checkbox"/> Occasionally | <input type="checkbox"/> Discomfort    |                                                              |
| <input type="checkbox"/> Often        | <input type="checkbox"/> Pain          |                                                              |
| <input type="checkbox"/> Always       | <input type="checkbox"/> Severe Pain   |                                                              |

| WRISTS/ HANDS                         |                                        | <input type="checkbox"/> right <input type="checkbox"/> left |
|---------------------------------------|----------------------------------------|--------------------------------------------------------------|
| <b>How often?</b>                     | <b>How Much?</b>                       |                                                              |
| <input type="checkbox"/> Never        | <input type="checkbox"/> No Discomfort |                                                              |
| <input type="checkbox"/> Occasionally | <input type="checkbox"/> Discomfort    |                                                              |
| <input type="checkbox"/> Often        | <input type="checkbox"/> Pain          |                                                              |
| <input type="checkbox"/> Always       | <input type="checkbox"/> Severe Pain   |                                                              |

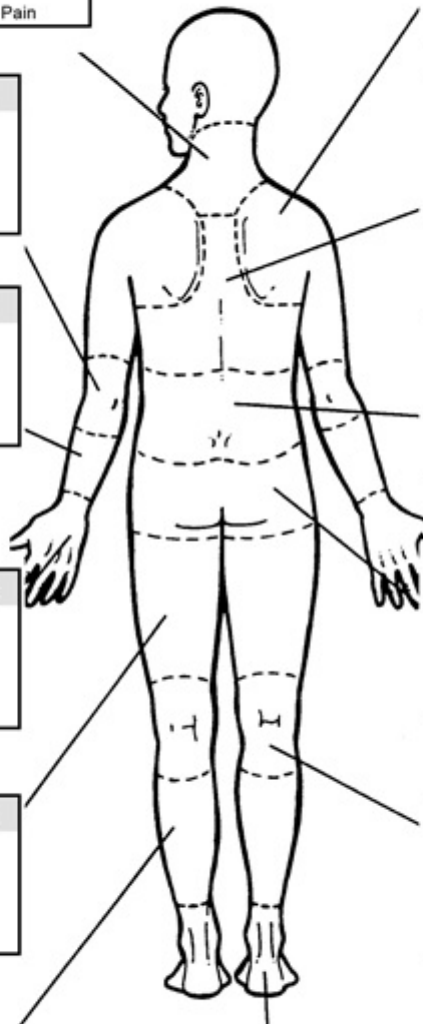
| HIPS                                  |                                        | <input type="checkbox"/> right <input type="checkbox"/> left |
|---------------------------------------|----------------------------------------|--------------------------------------------------------------|
| <b>How often?</b>                     | <b>How Much?</b>                       |                                                              |
| <input type="checkbox"/> Never        | <input type="checkbox"/> No Discomfort |                                                              |
| <input type="checkbox"/> Occasionally | <input type="checkbox"/> Discomfort    |                                                              |
| <input type="checkbox"/> Often        | <input type="checkbox"/> Pain          |                                                              |
| <input type="checkbox"/> Always       | <input type="checkbox"/> Severe Pain   |                                                              |

| THIGHS                                |                                        | <input type="checkbox"/> right <input type="checkbox"/> left |
|---------------------------------------|----------------------------------------|--------------------------------------------------------------|
| <b>How often?</b>                     | <b>How Much?</b>                       |                                                              |
| <input type="checkbox"/> Never        | <input type="checkbox"/> No Discomfort |                                                              |
| <input type="checkbox"/> Occasionally | <input type="checkbox"/> Discomfort    |                                                              |
| <input type="checkbox"/> Often        | <input type="checkbox"/> Pain          |                                                              |
| <input type="checkbox"/> Always       | <input type="checkbox"/> Severe Pain   |                                                              |

| KNEES                                 |                                        | <input type="checkbox"/> right <input type="checkbox"/> left |
|---------------------------------------|----------------------------------------|--------------------------------------------------------------|
| <b>How often?</b>                     | <b>How Much?</b>                       |                                                              |
| <input type="checkbox"/> Never        | <input type="checkbox"/> No Discomfort |                                                              |
| <input type="checkbox"/> Occasionally | <input type="checkbox"/> Discomfort    |                                                              |
| <input type="checkbox"/> Often        | <input type="checkbox"/> Pain          |                                                              |
| <input type="checkbox"/> Always       | <input type="checkbox"/> Severe Pain   |                                                              |

| LOWER LEGS                            |                                        | <input type="checkbox"/> right <input type="checkbox"/> left |
|---------------------------------------|----------------------------------------|--------------------------------------------------------------|
| <b>How often?</b>                     | <b>How Much?</b>                       |                                                              |
| <input type="checkbox"/> Never        | <input type="checkbox"/> No Discomfort |                                                              |
| <input type="checkbox"/> Occasionally | <input type="checkbox"/> Discomfort    |                                                              |
| <input type="checkbox"/> Often        | <input type="checkbox"/> Pain          |                                                              |
| <input type="checkbox"/> Always       | <input type="checkbox"/> Severe Pain   |                                                              |

| ANKLES / FEET                         |                                        | <input type="checkbox"/> right <input type="checkbox"/> left |
|---------------------------------------|----------------------------------------|--------------------------------------------------------------|
| <b>How often?</b>                     | <b>How Much?</b>                       |                                                              |
| <input type="checkbox"/> Never        | <input type="checkbox"/> No Discomfort |                                                              |
| <input type="checkbox"/> Occasionally | <input type="checkbox"/> Discomfort    |                                                              |
| <input type="checkbox"/> Often        | <input type="checkbox"/> Pain          |                                                              |
| <input type="checkbox"/> Always       | <input type="checkbox"/> Severe Pain   |                                                              |



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