Pre-Evaluation Client Questionnaire

Pre-Evaluation Client Questionnaire: Optimizing Your Workspace
Thank you for requesting an ergonomic evaluation!

To ensure we deliver the most tailored and effective ergonomic recommendations, please take a moment to complete the following questions. Your detailed responses will help us understand your unique needs and goals.

I. Contact & General Information

Name:
Phone Number:
Email Address:
Manager's Email Address:
Job Title:

II. Type of Request

Please select the primary reason for your request:

- ☐ **Ergonomic workstation evaluation**
- ☐ **Seating evaluation**
- ☐ **Information and demonstration of ergonomic workstation equipment**

III. Your Work & Daily Routine

1. In a paragraph, please explain what type of work you do, describing your main responsibilities and tasks.

2. Could you describe a typical workday for you? What does your workflow generally look like, from start to finish?

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3. How many hours per day, on average, do you spend sitting or standing at your desk?
   Sitting: 0-2 hours
   Standing: 0-2 hours
4. How many times per day, on average, do you speak on the phone while at work?

   0-5 times

5. Beyond your primary computer work, are there other activities you perform regularly at your desk, such as writing, reviewing documents, or using specific tools?

☐ Writing
☐ Reviewing documents
☐ Using specific tools (please describe)

☐ Other (please describe)

6. How often do you typically take breaks, and what do those breaks usually involve?

☐ Every 30-60 min,
☐ Every 1-2 hours
☐ A few times a day
☐ Rarely, Other (please specify)]

What do breaks usually involve?

7. Do you work from any other locations besides your primary office desk (e.g., home office, shared workspaces, on the go)? If so, how do those setups compare to your main office?

☐ No
☐ Yes (If yes, how do those setups compare to your main office?)

IV. Your Health & Discomfort

1. Do you have pain associated with sitting or standing at your desk?

☐ No
☐ Yes, please explain in detail:

2. Where exactly do you feel the discomfort? (Select all that apply)

☐ Neck
☐ Shoulders
☐ Upper Back
☐ Lower Back
☐ Wrists
☐ Other (please specify)
☐ Hands
☐ Fingers
☐ Eyes
☐ Hips
☐ Knees
☐ Ankles/Feet

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What does the pain feel like? (Select all that apply)

- [ ] Dull ache
- [ ] Sharp pain
- [ ] Tingling
- [ ] Numbness
- [ ] Burning
- [ ] Stiffness
- [ ] Swelling
- [ ] Weakness
- [ ] Other (please specify)

When does it tend to occur?

Specific times of day

Other (please specify)

On a scale of 1 to 10 (with 10 being the worst pain imaginable), what's your typical discomfort level on an average workday?

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

3. Have you experienced this discomfort for a while, or is it a more recent development?

A while (more than 3 months)

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4. Have you sought any medical attention for this discomfort, or are you currently undergoing any treatment?

☐ No
☐ Yes, please specify (e.g., physical therapy, chiropractor, medication, doctor's visits)

5. If you have a confirmed medical diagnosis from a doctor that you feel relates to your work, please explain it here.

6. Please list any other chronic medical conditions or significant accidents you've had in the last twenty (20) years that might be relevant to your workstation setup:

7. Do you wear any braces, insoles, or other prescribed devices (e.g., Bluetooth, headsets) while working?

☐ No
☐ Yes (please specify)

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V. Your Physical Characteristics

Height

Weight

Age Under 25

Dominant Hand ◯ Right-handed ◉ Left-handed

Do you have any known physical limitations, joint stiffness, or restricted range of motion that we should be aware of when assessing your setup?

☐ No

☐ Yes (please explain)

V. Your Current Workstation & Equipment

1. Can you describe your current workstation setup?
    - **Chair type** Standard office chair
      Other (Please specify)
    - **Desk type** Sit/stand desk (electric)
      Othe (Please specify)
2. What kind of computer equipment do you primarily use at your workstation?

☐ PC

☐ Laptop

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Do you use any of the following? (Select all that apply)

- ☐ Multiple monitors - If yes, how many?
- ☐ External keyboard
- ☐ External mouse
- ☐ Docking station
- ☐ Laptop stand

3. How many hours per day do you spend at the computer **outside of work** (e.g., using a home PC or laptop)? 0-1 hour

4. What type of lighting do you have at your workstation? Please be as specific as possible (e.g., overhead fluorescent, task lamp, natural light, window position).

- ☐ Overhead fluorescent lights
- ☐ Overhead LED lights
- ☐ Task lamp
- ☐ Natural light from window
- ☐ No specific task lighting
- ☐ Other (please describe):

5. Are you currently sitting directly in front of your screen?

- ☐ No
- ☐ Yes

6. Can you view your monitor without seeing glare on the screen?

- ☐ No
- ☐ Yes

7. Are your feet comfortably supported on the floor (or on a footrest) when you are seated at your desk?

No
Yes

8. Are your hips against the back of the chair when you are seated?

No
Yes

9. Is the backrest of your chair adjusted to properly support your back?

No
Yes

10. Is your seat long enough and wide enough to comfortably support your hips and thighs without causing pressure at the back of your knees?

No
Yes

11. Are there any other current challenges you face with your physical workspace that you've noticed yourself, even before our visit?

VII. Additional Information & Next Steps

Please use the box below for any additional information or comments you wish to provide (optional).

Please send two (2) pictures of yourself seated or standing at your desk (working) to info@ergonomicworks.com.

In the email heading, please include your **full name** and the title "**office ergonomic evaluation**".
It's ideal for the pictures to show as much of your body and workstation as possible.