

# Discomfort Survey

Name/email \_\_\_\_\_ Date     /     /      
Mo. Day Year

Job Title: \_\_\_\_\_ Dept: \_\_\_\_\_ Work Hours/Day \_\_\_\_\_ Break Time/Day \_\_\_\_\_  
Height: \_\_\_\_\_ Gender: F M Other \_\_\_\_\_

Typical Work Duties: *List your main work tasks*

Duty (i.e.: phone calls, spreadsheet, work processing)	Time (min or hours)

## GENERAL INFORMATION

1. Handedness:  Left Handed  Right Handed

2. Typical input method percentage: Mouse \_\_\_\_\_% Letter Keys \_\_\_\_\_% Number Keys/Pad \_\_\_\_\_%

3. Do you use a laptop for work?  Yes  No

a) If yes, how do you transport it?  Single shoulder strap  Backpack  Rollercase

4. How many monitors do you use at your workstation? \_\_\_\_\_

a) If more than one, do you turn your head to see each monitor?  Yes  No

5. Do you sit under dim or flickering lights?  Yes  No

6. Do you spend a lot of time looking down at papers on your desk?  Yes  No

7. Corrective Lens:  None  Single lens glasses  Bifocals  Trifocals  Progressives  Contacts

*For bifocals, trifocals, or progressives, what part of the lens do you look through for.*

a) To view the monitor:  Bottom  Middle  Top  N/A

b) To read paper documents:  Bottom  Middle  Top  N/A

c) When speaking to people:  Bottom  Middle  Top  N/A

### **How knowledgeable are you about your workstation adjustments?**

8. Chair adjustments:  Low  Medium  High

9. Monitor adjustments:  Low  Medium  High

10. Work surface (keyboard/mouse) adjustments:  Low  Medium  High

11. How long do you typically sit at one time without standing? \_\_\_\_\_ mins or hours (*circle one*)

### **Discomfort**

12. Have you ever had any pain or discomfort during the last year that you believe is related to your work?  Yes  No

13. If yes, please complete Page 2 of this survey.

# DISCOMFORT SURVEY

14. If you are experiencing any discomfort, list the areas in **priority order** (i.e.: begin with what you consider to be highest discomfort) and indicate its frequency and severity.

BODY AREA	FREQUENCY			SEVERITY		
	*Rarely	Sometimes	*Constantly	*Slightly Uncomfortable	Uncomfortable	*Very Uncomfortable

*\*Rarely = 1 or 2 times per week; \*Constantly = several times per day /*

*\*Slightly Uncomfortable = Slightly interferes with ability to work / \*Very Uncomfortable = Substantially interferes with ability to work*

15. When did you first notice this discomfort? \_\_\_\_\_ (month) \_\_\_\_\_ (year)

16. What would you attribute to the cause of this discomfort? Is there a specific task? \_\_\_\_\_

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17. Do you consider your discomfort to be a problem?

Yes  No

18. Do you have any suggestions to improve the ergonomic of your workstation and reduce your discomfort level?

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To be filled out by Admin:

Measurements in sitting

Desk Height:          inches                  Desk width:                  inches                  Desk depth (surface):                  inches

Seat Height:          inches

Working elbow Height:                  inches

Eye height:                  inches