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 Uncomforable	Uncomfortable	*Very Uncomforable

***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? ______________________________
____
____
____
____
____

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?
____
____
____
____
____
____

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