OPTIM ERGONOMICS

Occupational Health & Safety Ergonomic Survey for employees.

Enter your information here.

Please circle where appropriatte

First Name | Last Name

Company Name | Department or Division

Work Phone | Location

Staff ID Code

Email

Gender Male / Female

Would you like a workstation assessment as soon as possible? Yes / No

Rating Scale 0 No problem 1 Noticeable 2 Uncomfortable 3 Very Uncomfortable 4 Major Concern

Do you suffer from any of the following?

Question	Rating
1. Do you experience any pain or discomfort when working ?	0 1 2 3 4
2. Are you currently having treatment for any pain or discomfort or have you had treatment recently?	0 1 2 3 4
3. Do you have sore shoulders?	0 1 2 3 4
4. Do you have a sore neck?	0 1 2 3 4
5. Do you have sore hands or fingers?	0 1 2 3 4
6. Do you have sore wrists?	0 1 2 3 4
7. Do you have sore arms?	0 1 2 3 4
8. Do you have upper back pain?	0 1 2 3 4
9. Do you have pain between your shoulder blades?	0 1 2 3 4
10. Do you have pain in middle of your back?	0 1 2 3 4
11. Do you have lower back pain?	0 1 2 3 4
12. Do you have any tingling feeling in any part of your body?	0 1 2 3 4
13. Do you have any numb feeling in any part of your body ?	0 1 2 3 4
14. Do you have dry and/or watery eyes ?	0 1 2 3 4
15. Do you find it hard to sit upright?	0 1 2 3 4
16. Do you have any acute pain anywhere in your body?	0 1 2 3 4

17. Are there any other identifiable Occupational Health and Safety hazards or concerns in your work area?
1. lightning 2. temperature 3. furniture 4. ventilation 5. noise
other please specify: