Columbia Basin College
Ergonomics Program - Symptoms Survey

Date _____ / _____ / _____

Last Name _____ (optional) First Name _____ (optional)

Work Location _____ Job _____

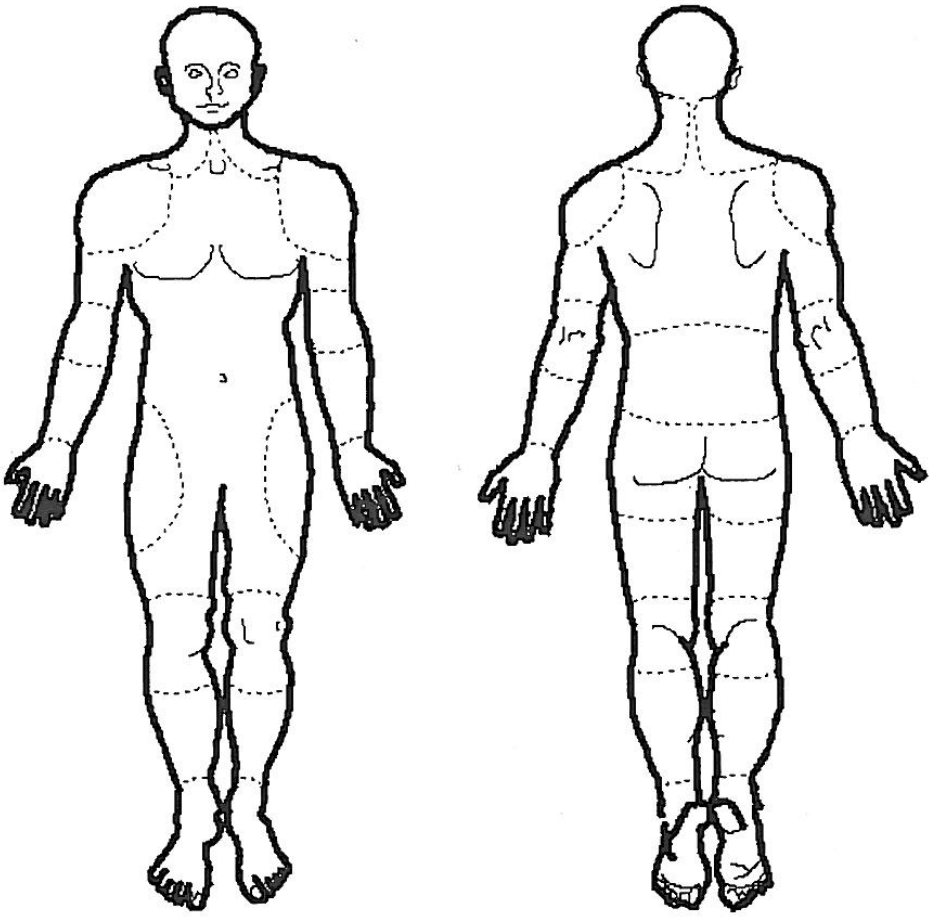
Shift _____ Supervisor _____ (optional)

Time on THIS job: ❑ Less than 3 months ❑ 3 months to 1 year
❑ Greater than 1 year to 5 years ❑ Greater than 5 years to 10 years
❑ Greater than 10 years

Have you had any pain or discomfort during the last year?

❑ Yes ❑ No (If NO, stop here)

If YES, carefully shade in the area of the drawings below which bothers you the MOST:



Symptoms Survey

Name (optional) _____

Please complete a separate page for each area that bothers you.

Check area: ❑ Neck ❑ Shoulder ❑ Elbow/Forearm ❑ Hand/Wrist ❑ Fingers
❑ Upper Back ❑ Low Back ❑ Thigh/Knee ❑ Lower Leg ❑ Ankle/Foot

1. Please put a check by the word(s) that best describe your problem:

_____ 1) Aching/Cramp	_____ 4) Numbness/Tingling	_____ 7) Stiffness
_____ 2) Burning	_____ 5) Pain	_____ 8) Weakness
_____ 3) Loss of Color	_____ 6) Swelling	_____ 9) Other

2. When did you first notice the problem? _____ number of months -or- _____ years ago

3. How long does each episode last? (please check)

_____ 1) Less than 1 hour	_____ 3) 24 hours to 1 week	_____ 5) 1 month to 6 months
_____ 2) 1 hour to 24 hours	_____ 4) 1 week to 1 month	_____ 6) more than 6 months

4. How many separate episodes have you had in the last year? _____

5. What do you think caused the problem? _____

_____

6. Have you had the problem in the last 7 days? ❑ Yes ❑ No

OPTIONAL

7. How would you rate this problem? Mark an X on the line.

RIGHT NOW: **None** _____ **Unbearable**

AT ITS WORST: **None** _____ **Unbearable**

8. Have you had medical treatment for this problem? ❑ Yes ❑ No
   If yes, what was the diagnosis? _____

9. How much time have you lost from work in the last year because of this problem? _____ days

10. How many days in the last year were you on modified duty because of this problem? _____ days

11. Have you changed jobs because of this problem? ❑ Yes ❑ No

12. Please comment on what you think would improve your symptoms: _____

_____

Please submit completed form to mstewart@columbiabasin.edu