UHS | UNIVERSITY HEALTH SERVICES
Promoting, protecting, and restoring health and well-being

Ergonomic Intake Survey (non-computer)

Employee Name: _____ Date: _____

Work Location: _____ Position Title: _____

Hints to Locate Your Workstation: _____

_____

What are you hoping to accomplish from this assessment request? _____

_____

_____

_____

Phone: _____ Work Hours: _____ Supervisor: _____

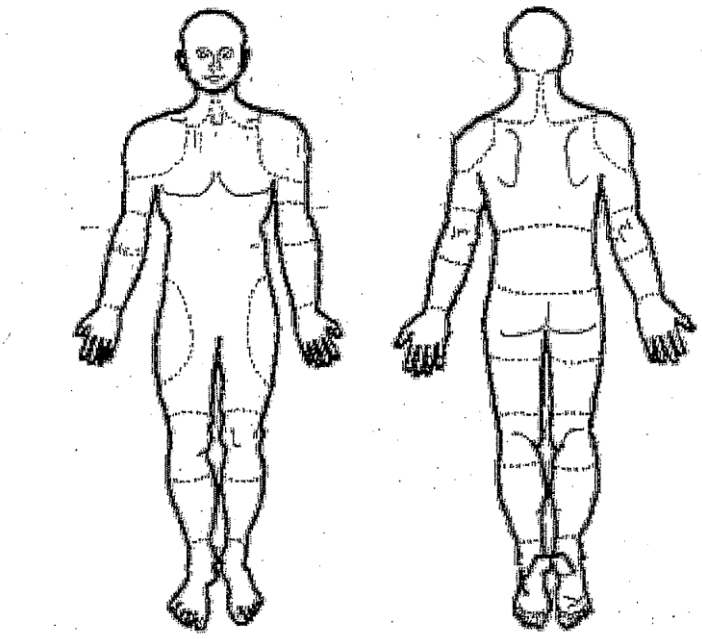
Time on THIS job:

☐ Less than 3 months ☐ 3 months to 1 year ☐ 1 to 5 years
☐ 5 to 10 years ☐ Greater than 10 years

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

   ☐ Yes ☐ No (If no, skip to next page)

2. If yes, please shade in the area of the drawings below which bothers you the MOST:



3. If yes, please check areas where symptoms are present:

☐ Neck ☐ Elbow/Forearm ☐ Upper Back ☐ Thigh/Knee ☐ Fingers

☐ Shoulder ☐ Hand/Wrist ☐ Lower Back ☐ Lower Leg ☐ Ankles/Foot

4. If yes, please put a check by the words that best describe your discomfort:

☐ Aching/Cramp ☐ Numbness/Tingling ☐ Stiffness

☐ Burning ☐ Pain ☐ Weakness

☐ Loss of Color ☐ Swelling ☐ Other? _____

5. When did you first notice this? _____ number of months -or- _____ years ago

6. What do you think caused these symptoms? _____

_____

7. Have you had medical treatment for these symptoms? ☐ Yes ☐ No

8. Have you lost time from work in the last year because of these symptoms?

☐ Yes ☐ No

If yes, how many days? _____days

9. Have you changed jobs because of this problem? ☐ Yes ☐ No

10. Please comment on what you think would improve your work condition(s):

_____

_____

_____

_____

_____

We will contact you soon for scheduling options upon reviewing this information.