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):

    _____________________________________________________________________

    _____________________________________________________________________

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

University Health Services  |  Environmental & Occ Health  |  University of Wisconsin- Madison
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