



The University of Western Ontario MSD Prevention Program

Worker Discomfort Survey– Form 1B

The worker is asked to rate their level of discomfort for each body region by numbering their pain on a scale from 0-10. A score of 0 indicates no discomfort while a score of 10 indicates the worst discomfort ever experienced. All workers who perform a job should take part in the survey. For further information: http://www.uwo.ca/humanresources/facultystaff/h_and_s/rehab/ergonomics/index.htm

Date: _____ **Job:** _____ **Area:** _____

Hours worked/week : _____ **Time on THIS Job:** _____ Years _____ Months

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

[] Yes [] No (if NO, Stop here)

2. If YES, please rate the level of discomfort over the last MONTH by completing the ‘how much?’ box using the scale of 0 to 10, with 0 being no discomfort and 10 being the worst discomfort ever.

How often? Rarely <input type="checkbox"/> Occasionally <input type="checkbox"/> Frequently <input type="checkbox"/> Constantly <input type="checkbox"/>	How much? _____	Neck		Right Shoulder	How often? Rarely <input type="checkbox"/> Occasionally <input type="checkbox"/> Frequently <input type="checkbox"/> Constantly <input type="checkbox"/>	How much? _____
How often? Rarely <input type="checkbox"/> Occasionally <input type="checkbox"/> Frequently <input type="checkbox"/> Constantly <input type="checkbox"/>	How much? _____	Left Shoulder		Upper Back	How often? Rarely <input type="checkbox"/> Occasionally <input type="checkbox"/> Frequently <input type="checkbox"/> Constantly <input type="checkbox"/>	How much? _____
How often? Rarely <input type="checkbox"/> Occasionally <input type="checkbox"/> Frequently <input type="checkbox"/> Constantly <input type="checkbox"/>	How much? _____	Left Elbow / Forearm		Right Elbow / Forearm	How often? Rarely <input type="checkbox"/> Occasionally <input type="checkbox"/> Frequently <input type="checkbox"/> Constantly <input type="checkbox"/>	How much? _____
How often? Rarely <input type="checkbox"/> Occasionally <input type="checkbox"/> Frequently <input type="checkbox"/> Constantly <input type="checkbox"/>	How much? _____	Left Wrist / Hand		Lower Back	How often? Rarely <input type="checkbox"/> Occasionally <input type="checkbox"/> Frequently <input type="checkbox"/> Constantly <input type="checkbox"/>	How much? _____
How often? Rarely <input type="checkbox"/> Occasionally <input type="checkbox"/> Frequently <input type="checkbox"/> Constantly <input type="checkbox"/>	How much? _____	Left Hip / Thigh / Buttock		Right Hand / Wrist	How often? Rarely <input type="checkbox"/> Occasionally <input type="checkbox"/> Frequently <input type="checkbox"/> Constantly <input type="checkbox"/>	How much? _____
How often? Rarely <input type="checkbox"/> Occasionally <input type="checkbox"/> Frequently <input type="checkbox"/> Constantly <input type="checkbox"/>	How much? _____	Left Knee		Right Hip / Thigh / Buttock	How often? Rarely <input type="checkbox"/> Occasionally <input type="checkbox"/> Frequently <input type="checkbox"/> Constantly <input type="checkbox"/>	How much? _____
How often? Rarely <input type="checkbox"/> Occasionally <input type="checkbox"/> Frequently <input type="checkbox"/> Constantly <input type="checkbox"/>	How much? _____	Left Ankle / Foot		Right Knee	How often? Rarely <input type="checkbox"/> Occasionally <input type="checkbox"/> Frequently <input type="checkbox"/> Constantly <input type="checkbox"/>	How much? _____
				Right Ankle / Foot	How often? Rarely <input type="checkbox"/> Occasionally <input type="checkbox"/> Frequently <input type="checkbox"/> Constantly <input type="checkbox"/>	How much? _____

If you are a recent hire, please list other jobs you have done in the last year (for more than 2 weeks)

Note: If more than 2 jobs, only include those you worked on the most

Job _____ Time on THIS Job _____ months _____ weeks

Job _____ Time on THIS Job _____ months _____ weeks

3. When did you first notice your discomfort? _____ (month) _____ (year)

4. What do you think caused the discomfort? Is it a specific task?

5. Please comment on what you think would help to reduce your level of discomfort. Any changes or recommendations you would make to the work environment to reduce risk of injury?

6. Do you consider your discomfort to be a problem?

Yes No

7. Have you have missed time from work (vacation, sick days,) or attended medical review as a result of your work related discomfort?

Yes No

If yes, and you have not already completed an Accident/ Incident Report, you are required to notify your supervisor to follow the reporting process.