

EMPLOYEE COMFORT SURVEY

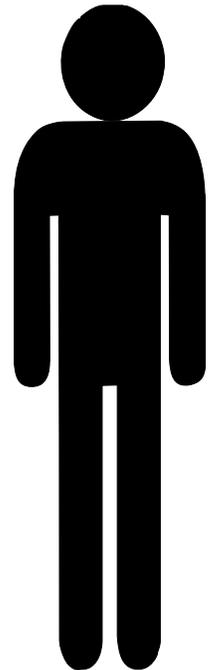
INITIAL
 FOLLOW UP

Please rate your body before or after the Ergonomic intervention for your comfort or energy level at day's end.

Project Number:	Ergonomist:	Phone:
Project Shop Code:	Employees Name:	Phone:
Specific task:		

Answer only for the areas affected by this task in the section below. Blank indicates "no problem"/

- (A) Head/Eyes ()
 - (B) Neck ()
 - (C) Shoulders ()
 - (D) High Back ()
 - (E) Elbow ()
 - (F) Forearm ()
 - (G) Wrist ()
 - (H) Hand/Fingers ()
 - (I) Low Back ()
 - (J) Hip ()
 - (K) Upper Leg ()
 - (L) Knee ()
 - (M) Ankle ()
 - (N) Foot ()
 - (O) Chest ()
 - (P) Abdomen ()
- Use codes F, D, P, or I to indicate comfort level at the end of any day after doing subject task.
- F = Fatigue**
D = Discomfort
P = Pain
I = Injury
- Use arrows or circle to indicate affected area of the "body" to your right. Assume the "person" is walking away from you.



If you have reported a previous injury (work or personal) in any of these areas on your original comfort survey, are the discomfort symptoms reduced by this intervention?

Body Part: _____

Injury: _____

Date Injured: (Approx.): _____

Was your recovery complete? _____

Have you completed any ergonomic training? No Yes (give date(s)) _____

Additional Comments:

Note: This information is CONFIDENTIAL and will not be revealed to anyone other than the assigned Ergonomist and Ergo Team (as a part of a review of risk factors for this project.)

Job Factor:

Please answer the questions below with a number from "0"(very little) to "10" (maximum)

How HARD is your work physically?	()
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How HARD is your work mentally?	()
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How much ENERGY do you typically have left after work?	()
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How would you rate your own workplace MORALE?	()
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Is there anything that could be done to make your work safer or easier?

Additional Comments:

All fields are required.

ALL required fields on this form must be completed and those not required indicate N/A.