

ERGONOMIC COMFORT SURVEY

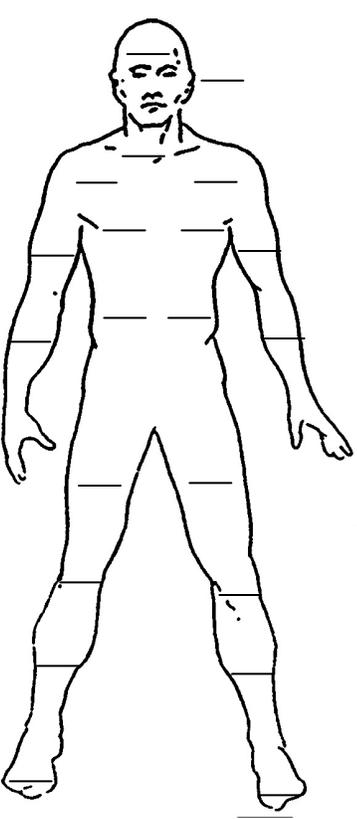
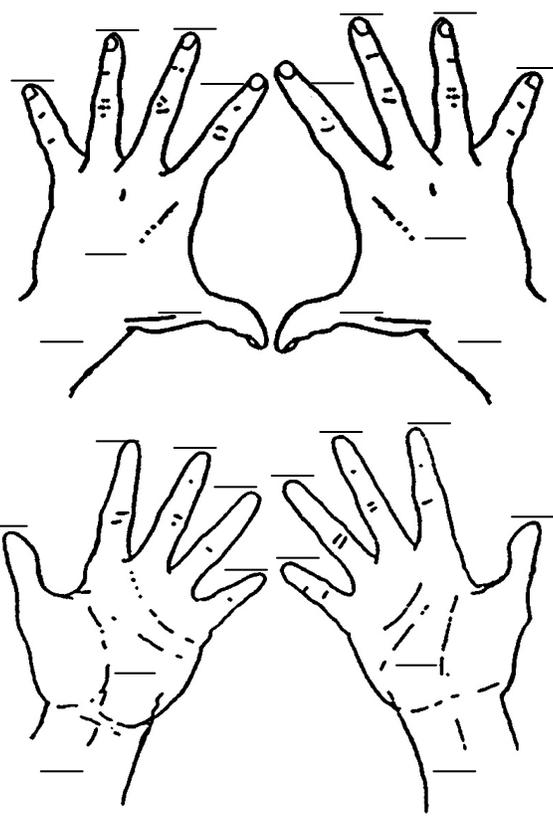
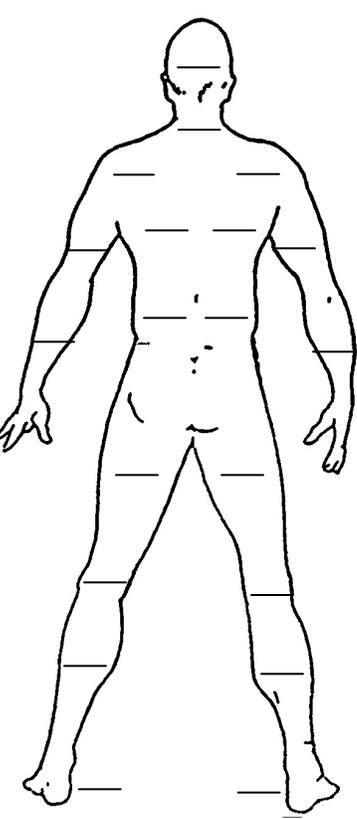
NAME <i>(Optional unless for personal worksite visit)</i>		DATE
PHONE	BUILDING	ROOM
JOB TITLE		CODE

CHECK THE NUMBER ON A SCALE OF 0 - 10 TO DESCRIBE YOUR LEVEL OF DISCOMFORT.

NO DISCOMFORT AT ALL = 0					WORST IMAGINABLE DISCOMFORT = 10					
AT YOUR WORST:										
0	1	2	3	4	5	6	7	8	9	10
AT YOUR BEST:										
0	1	2	3	4	5	6	7	8	9	10
CURRENTLY:										
0	1	2	3	4	5	6	7	8	9	10

DESCRIBE DISCOMFORT YOU ARE HAVING IN ANY PART OF YOUR BODY.

A = Aching S = Stabbing NT = Numb/Tingle P = Pain ST = Stiff B = Burning SW = Swell O = Other

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INDICATE WHETHER ANY OF THE FOLLOWING CONDITIONS CREATE PROBLEMS IN YOUR JOB.

Never Sometimes Frequently Constantly

- Temperature
- Drafts
- Odors
- Equipment noise
- Distracting noise
- Chair comfort
- Backrest comfort
- Workspace
- Storage space
- Legroom
- Table height
- Keyboard height
- Place to rest arms
- Amount of light
- Glare from light
- Glare from window
- Reflections on desks
- Reflections on VDT

COMMENTS

INDICATE HOW OFTEN YOU HAVE EXPERIENCED EACH OF THE FOLLOWING LISTED BELOW WITHIN THE PAST SIX MONTHS.

Never Sometimes Frequently Constantly

- Pain or stiffness in your arms
- Pain or stiffness in your neck
- Pain or stiffness in your shoulders
- Pain or stiffness in your back
- Burning eyes
- Eyestrain
- Headaches
- Leg cramps

COMMENTS