DISCOMFORT SURVEY

Date:	Evaluator:

Job Information

Name:	Years on Job:
Position:	

Rate your physical discomfort on a scale of 0 to 5, where 0 = no discomfort and 5 = moderate to severe discomfort and/or constant symptoms.

Body Part	Right	Left	Task(s) that usually causes discomfort
Hand/wrist			
Elbow			
Shoulder			
Neck			
Back			
Legs			
Headache/eyestrain			
Other			

1. Have you sought or received medical assistance or treatment (physio/chiro/family doctor/etc.) for any of these body parts? ☐ Yes ☐ No

   If yes, please specify:

2. Have there been any changes made to your workstation or job tasks that you must perform to do your job? ☐ Yes ☐ No

   If yes, please specify:

3. *Do you have any suggestions that may improve your job?*

APRIL 2026