# Symptoms Survey Form

| | |
|---|---|
| **Last Name:** | **First Name:** |
| **Work Location:** | **Title:** |
| **Supervisor:** | **Shift:** |

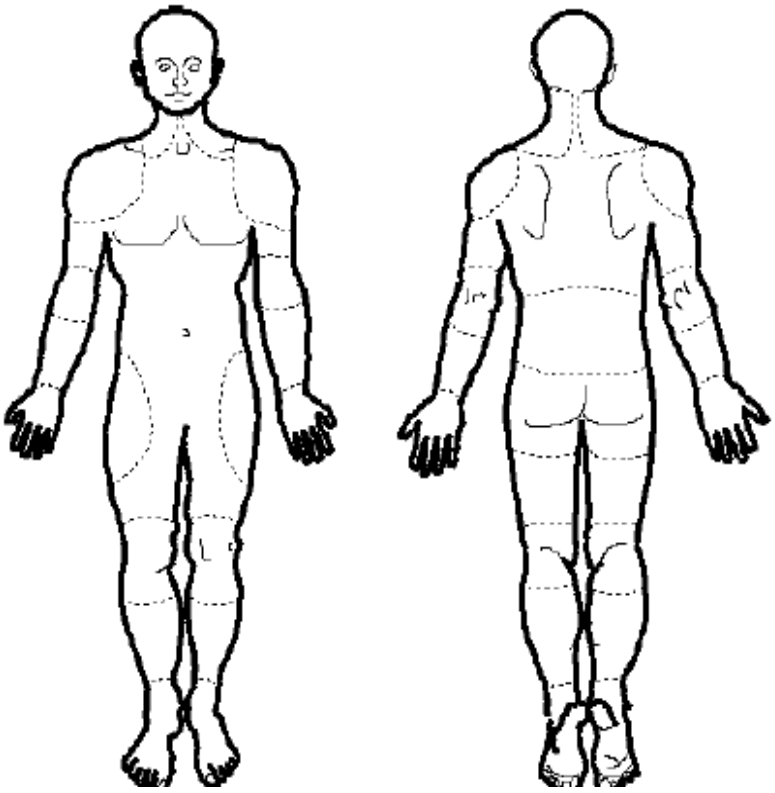
**Period of time at this position:**

- ☐ Less than 3 months
- ☐ 3 months to 1 year
- ☐ Greater than 1 year – 5 years
- ☐ Greater than 5 years – 10 years
- ☐ Greater than 10 years

**Have you had any pain or discomfort during the last year?**

☐ **Yes** ☐ **No**

**If yes, carefully shade in the area of the drawings below with respect to the part of your body that bothers you the MOST :**



## Symptoms Survey

**Name (optional)** _____

*Please complete a separate page for each area of the body that bothers you.*

**Check Area:**

☐ **Neck** ☐ **Shoulder** ☐ **Elbow/Forearm** ☐ **Hand/Wrist** ☐ **Fingers**
☐ **Thigh/Knee** ☐ **Low Back** ☐ **Upper Back** ☐ **Lower Leg** ☐ **Ankle / Foot**

1. Please put a check by the word(s) that best describe your problems:

_____1) Aching/Cramp _____4) Numbness/Tingling _____7) Stiffness

_____2) Burning _____5) Pain _____8) Weakness

_____3) Loss of Color _____6) Swellng _____9) Other Symptom

2. When did you first notice the problem? _____ number of months -or-_____ years ago

3. How long does each episode last? (please check)

_____1) Less than 1 hour _____ 3) 24 hours to 1 week _____ 5) 1 month to 6 months

_____2) 1 hour to 24 hours _____4) 1 week to 1 month _____ 6) more than 6 months

4. How many separate episodes have you had in the last year? _____

5. What do you think caused the problem? _____

6. Have you had the problem in the last 7 days? ☐ YES ☐ NO

**OPTIONAL**

7. How would you rate this problem? Mark an X on the line.
   RIGHT NOW : None _____ Unbearable
   AT ITS WORST: None _____ Unbearable

8. Have you had medical treatment for this problem? ☐ YES ☐ NO
   If yes, what was the diagnosis? _____

9. How much time have you lost from work in the last year because of this problem? _____

10. How many days in the last year were you on modified duty because of this problem?

11. Have you changed jobs because of this problem ☐ YES ☐ NO

12. Please comment on what you think would improve your symptoms: _____