



# Office ErgoProfile Employee Survey

## WHAT YOU DO

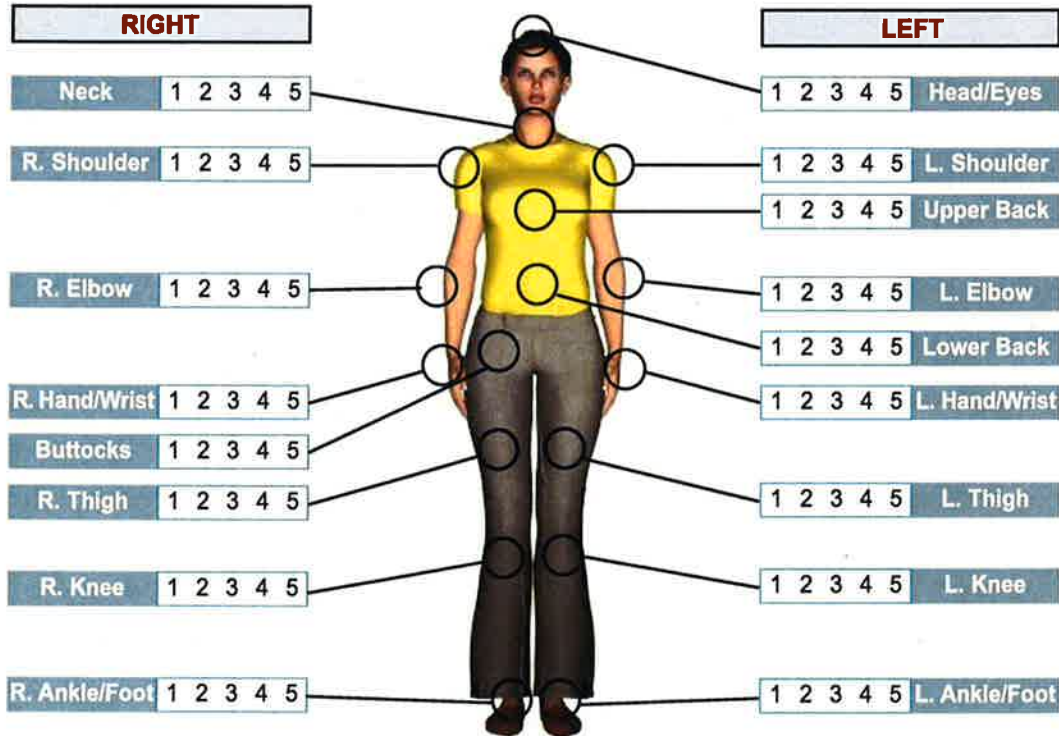
Department \_\_\_\_\_  
 Job \_\_\_\_\_  
 Supervisor \_\_\_\_\_  
 Shift 1 2 3 Other: \_\_\_\_\_

Date \_\_\_\_\_  
 Gender M F  
 Age (years) \_\_\_\_\_  
 How long have you worked for this company? \_\_\_\_\_

## HOW YOU FEEL

Do you experience musculoskeletal discomfort that you feel is related to your work tasks?  
**YES** (If yes, please complete the discomfort chart below)      **NO** (If no, skip to "tell us about your job" section)

For any body part having discomfort, circle the number that ranks the discomfort level. 1=some discomfort, 2, 3, 4, 5=very uncomfortable



## FOR THE AREA OF MOST DISCOMFORT, ANSWER THE FOLLOWING (CIRCLE #):

Which body part has the highest discomfort and is of most concern to you? \_\_\_\_\_

A. How long has it been since you started to experience the discomfort?

- 1- days
- 2- weeks
- 3- months
- 4- years

B. How often do you experience the discomfort?

- 1- always, constantly
- 2- occasionally
- 3- at rest
- 4- when active

C. How did the discomfort start?

- 1- gradually, over time
- 2- suddenly
- 3- injury/accident

## TELL US ABOUT YOUR JOB

Circle the specific part of your job that is of concern to you.

<b>Workplace</b>	no concern	chair	desk	office layout	adjustability	heights	reaches	flooring
<b>Work/Job</b>	no concern	tasks	breaks	pace	deadlines	variety		
<b>Office Tools</b>	no concern	size	shape	function correctly	ease of use	location	compatibility	
<b>Materials Handling</b>	no concern	lifting	weight	push/pull	carrying	frequency		
<b>Environment</b>	no concern	temperature	ventilation	lighting	noise	vibration		

## YOUR THOUGHTS

What do you think would make your job easier? \_\_\_\_\_

If you have specific concerns about your job, write them here. \_\_\_\_\_