



Symptoms Survey Form

Last Name:

First Name:

Work Location:

Title:

Supervisor:

Shift:

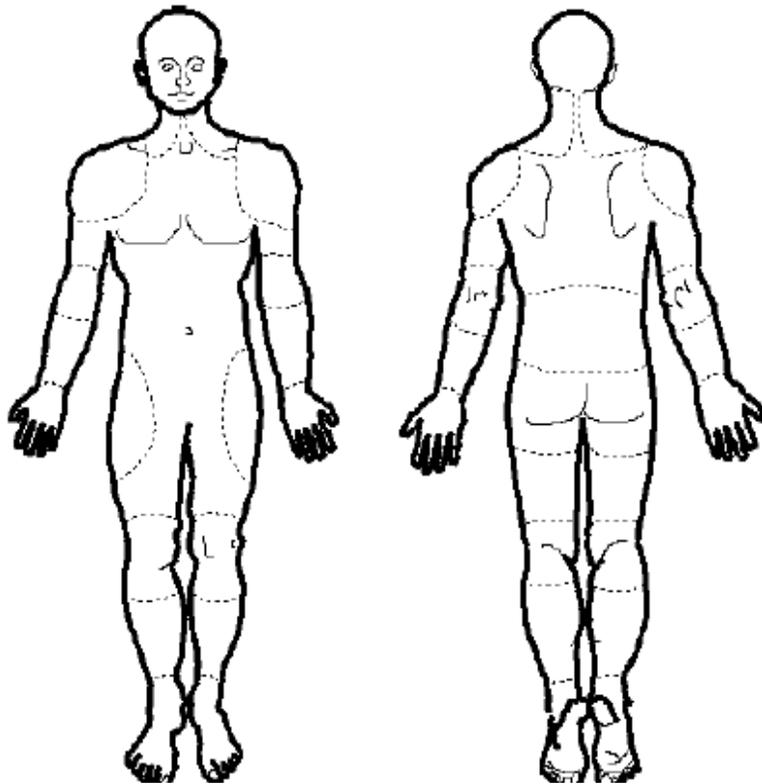
Period of time at this position: Less than 3 months
 3 months to 1 year
 Greater than 1 year – 5 years
 Greater than 5 years – 10 years
 Greater than 10 years

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)	
<i>Please complete a separate page for each area of the body that bothers you.</i>	
Check Area:	
<input type="checkbox"/> Neck	<input type="checkbox"/> Shoulder
<input type="checkbox"/> Thigh/Knee	<input type="checkbox"/> Low Back
<input type="checkbox"/> Elbow/Forearm	<input type="checkbox"/> Upper Back
<input type="checkbox"/> Hand/Wrist	<input type="checkbox"/> Lower Leg
<input type="checkbox"/> Fingers	<input type="checkbox"/> Ankle / Foot
1. Please put a check by the word(s) that best describe your problems:	
_____ 1) Aching/Cramp	_____ 4) Numbness/Tingling
_____ 2) Burning	_____ 5) Pain
_____ 3) Loss of Color	_____ 6) Swelling
_____ 7) Stiffness	_____ 8) Weakness
_____ 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
_____ 2) 1 hour to 24 hours	_____ 4) 1 week to 1 month
_____ 5) 1 month to 6 months	_____ 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? <input type="checkbox"/> YES <input type="checkbox"/> NO	
<u>OPTIONAL</u>	
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? <input type="checkbox"/> YES <input type="checkbox"/> 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 <input type="checkbox"/> YES <input type="checkbox"/> NO	
12. Please comment on what you think would improve your symptoms: _____	