Symptoms Survey with a Body Map

Date ____ / ____ / _________
Company/Plant ____________________  Dept __________________________
Job Name __________________________________________________________
Shift ____________  Hrs worked/week _______  Time on this job ____yrs ____ mos

<table>
<thead>
<tr>
<th>Company</th>
<th>Department</th>
<th>Job Name</th>
<th>Time on this job</th>
</tr>
</thead>
<tbody>
<tr>
<td>______</td>
<td>______</td>
<td>________________</td>
<td>_____ mos _____ weeks</td>
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<tr>
<td>______</td>
<td>______</td>
<td>________________</td>
<td>_____ mos _____ weeks</td>
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</tbody>
</table>

Other jobs you have done in the last year (for more than 2 weeks). If more than 2 jobs, include those you worked on the most.

Have you had any pain or discomfort during the last year?
☐ Yes (Continue to next question)  ☐ No (If NO, stop here)

Continue to next page
If YES, carefully shade in area of the drawing that bothers you the MOST.

[Front ]

[Back ]
*This page can be copied and completed for each body area where the discomfort/pain is felt.*

Check body area of discomfort/pain:
- Neck
- Shoulder
- Elbow/Forearm
- Hand/Wrist
- Fingers
- Upper Back
- Low Back
- Thigh/Knee
- Low Leg
- Ankle/Foot

1. Please check the word(s) that best describe your problem:
- Aching
- Numbness (feels asleep)
- Tingling
- Burning
- Pain
- Weakness
- Cramping
- Swelling
- Other ________________________
- Loss of color
- Stiffness

2. When did you first notice the problem? ____________ (month) ____________ (year)

3. How long does each episode last? (*Mark an X along the line*)

|_________|_________|_________|_________|_________|________|________|
| 1 minute | 1 hour  | 1 day   | 1 week  | 1 month | 6 months| 1 year |

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

5. What do you think caused the problem? ____________________________________________________
_________________________________________________________________________________________

6. Have you had this problem in the last 7 days?    ☐ Yes    ☐ No

7. How would you rate the severity of this problem? (*Circle the number that corresponds to your rating*)

Now: 1 2 3 4 5 6 7
None  Unbearable

When it’s the worst: 1 2 3 4 5 6 7
None  Unbearable

8. Have you had medical treatment for this problem?    ☐ Yes    ☐ No

8a. If NO, why not? _______________________________________________________

8b. If YES, where did you receive treatment?
- Company medical   Times in past year: ____________
- Personal doctor   Times in past year: ____________
- Other              Times in past year: ____________

8c. Did treatment help? ☐ Yes    ☐ No

9. How much time have you lost in the last year because of this problem? _________ days

10. How many days in the last year were you on restricted/light duty because of this problem? _________ days

11. Please comment on what you think would improve your symptoms: ________________________________
_________________________________________________________________________________________

_________________________________________________________________________________________