Symptoms Survey Form

Current Job Information

Plant _______________ Dept # _______________ Job Name _____________________

Shift __________ Hours Worked/Week _____ Time on this Job _____Years _____Months

Other jobs you have done in the last year (for more than 2 weeks)

Plant _______________ Dept # _______________ Job Name _____________________

Time on this Job _____Years _____Months

Plant _______________ Dept # _______________ Job Name _____________________

Time on this Job _____Years _____Months

Have you had pain or discomfort during the last year?

[ ] Yes [ ] No *(If NO, stop here)*

If YES, carefully shade in the area of the drawing which bothers you the MOST.
(Complete a separate page for each area that bothers you)

Check Area:

[ ] Neck [ ] Shoulder [ ] Elbow/Forearm [ ] Hand/Wrist [ ] Fingers
[ ] Upper Back [ ] Low Back [ ]Thigh/Knee [ ]Low Leg [ ]Ankle/Foot

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

[ ] Aching [ ] Numbness (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? _____(1 hour) _____(1 day) _____(1 week) ______(1 month) _____(6 months)

4. How many separate episodes have you had in the past year? ____

5. What do you think caused the problem? ____
____

6. Have you had the problem in the last 7 days? [ ] Yes [ ] No

7. How would you rate this problem? (mark an X on the line)

Now:
None ____Unbearable

When it is the WORST:
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?

[ ] 1. Company Medical Times in past year __________ Did the treatment help? [ ] Yes [ ] No
[ ] 2. Personal Doctor Times in past year __________ Did the treatment help? [ ] Yes [ ] No
[ ] 3. Other Times in past year __________ Did the 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 or light duty because of this problem? __________days

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

____
____
____
____
____
____
____
____