

Worker Discomfort Survey

Date		Job name		Department	
Shift		Hours worked		Time on this job	

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

Note: If more than two jobs, only include those you worked on the most

Plant	Department	Job Name	Time on this job (months and weeks)

1. Have you had pain or discomfort during the last year that you feel is job-related?

- Yes
- No (if no, stop here)

2. If Yes, please rate the level of discomfort over the last month by checking off the appropriate box using the scale of 0 to 10, with 0 being no discomfort and 10 being the worst discomfort experienced.

When did you first notice your discomfort? (month and year)	
What do you think caused the discomfort?	
Please comment on what you think would help to reduce your level of discomfort.	
Do you consider your discomfort to be a problem?	Yes / No
Have you received medical treatment (doctor, chiropractor, physiotherapist, massage therapist or other healthcare practitioner) for your discomfort?	Yes / No
Have you taken time off work as a result of your discomfort (vacation, sick days, lost time claim, medical aid)?	Yes / No

Modified from Part 3B: MSD Prevention Toolbox – Beyond the Basics
 Developed by Occupational Health and Safety Council of Ontario (OHSCO)