Worker Discomfort Survey

Completed By:	Date:	
Job Name:	Shift:	
Department:	Time on Job:	

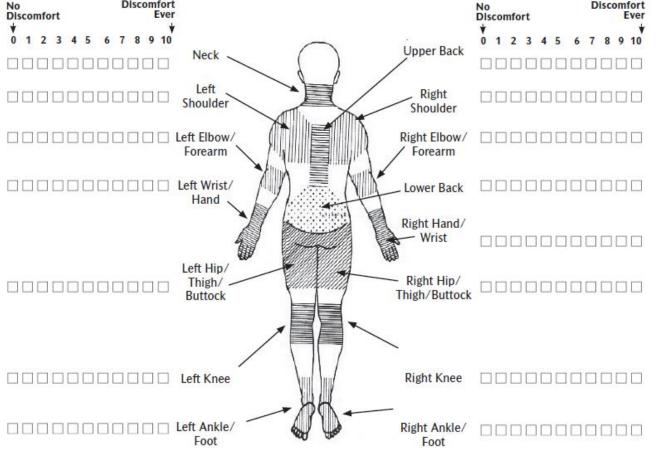
Please list other jobs you have done in the last year (for more than two weeks). **Note:** If more than two jobs, only include those you worked on the most

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

☐ No (if 'No', stop here)

Plant	Job Name	Department	Time on Job

2. If 'Yes', please rate the level of discomfort <u>over the last month</u> by checking off the appropriate box using the scale of 0 to 10, with 0 being no discomfort and 10 being the worst discomfort ever.		14.	Worst	3	3		Worst
	2.					_	





☐ Yes

С	ompleted By:	Date	Date:		
3.	When did you first notice your discomfort?				
		(month)	(year)		
4.	What do you think caused the discomfort?				
5.	Please comment on what you think would help to re	educe your level of dis	scomfort.		
		•			
6.	Do you consider your discomfort to be a problem? ☐ Yes ☐ No				
	□ TeS □ NO				
7.	Have you received medical treatment (from a doctor therapist or other health care practitioner) for your	or, chiropractor, physic	therapist, massage		
	☐ Yes ☐ No	alsoormore:			
	□ 169 □ 140				
8.	Have you taken time off work because of your disc medical aid)?	omfort (vacation, sick	days, lost time claim,		
	□ Yes □ No				

Content sourced from the MSD Prevention Guideline for Ontario, Part 3B: MSD Prevention Toolbox (2007)