Symptoms Survey with a Body Map

Date ____ / ____ / _____

Company/Plant _____ Dept _____

Job Name _____

Shift _____ Hrs worked/week _____ Time on this job ____yrs ____ mos

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.

_____	_____	_____	_____ mos _____weeks
Company	Department	Job Name	Time on this job
_____	_____	_____	_____ mos _____weeks
Company	Department	Job Name	Time on this job

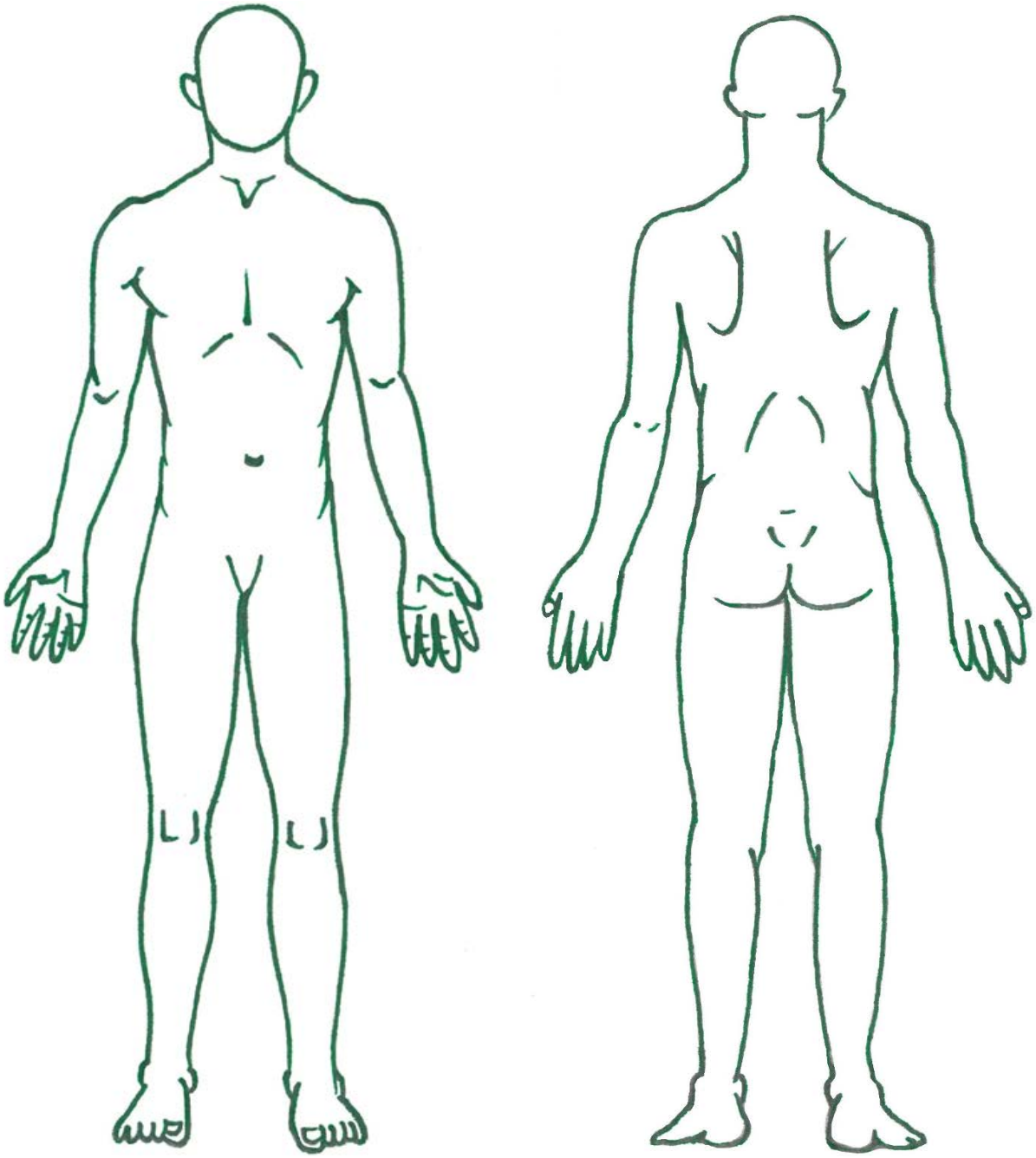
Have you had any pain or discomfort during the last year?

☐ 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 None	2	3	4	5	6	7 Unbearable
When it's the worst:	1 None	2	3	4	5	6	7 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: _____

_____