



SYMPTOM SURVEY

Company _____
 Name _____ Date _____
 Email _____ Supervisor _____
 Job Title _____
 Years with Company _____
 Phone _____

	YES	NO
1. Is there numbness/tingling/pins-needles sensations in the hands?		
2. Is there soreness or pain in the wrist/forearm/elbow?		
3. Is there soreness or pain at the shoulder?		
4. Is there soreness or pain along the neck/shoulder region?		
5. Is there soreness or pain between the shoulder blades?		
6. Is there low back pain?		
7. Are symptoms being treated?		
8. Are symptoms improving?		
9. Is this a workers' compensation claim?		
10. Do your eyes become sore/tired at the end of the day?		
11. Do you experience headaches related to monitor use?		
12. Eye correction: none, single lens, bifocals, trifocals, contacts		

Please rate the level of pain or soreness using the 5-point scale. If the pain is associated with a specific task, please indicate the task.

Mild pain Moderate Pain Extreme pain
 1-----2-----3-----4-----5

BODY PART	PAIN LEVEL (1-5)	SPECIFIC JOB TASK

Additional Comments
