# Office Ergo*Profile* Employee Survey

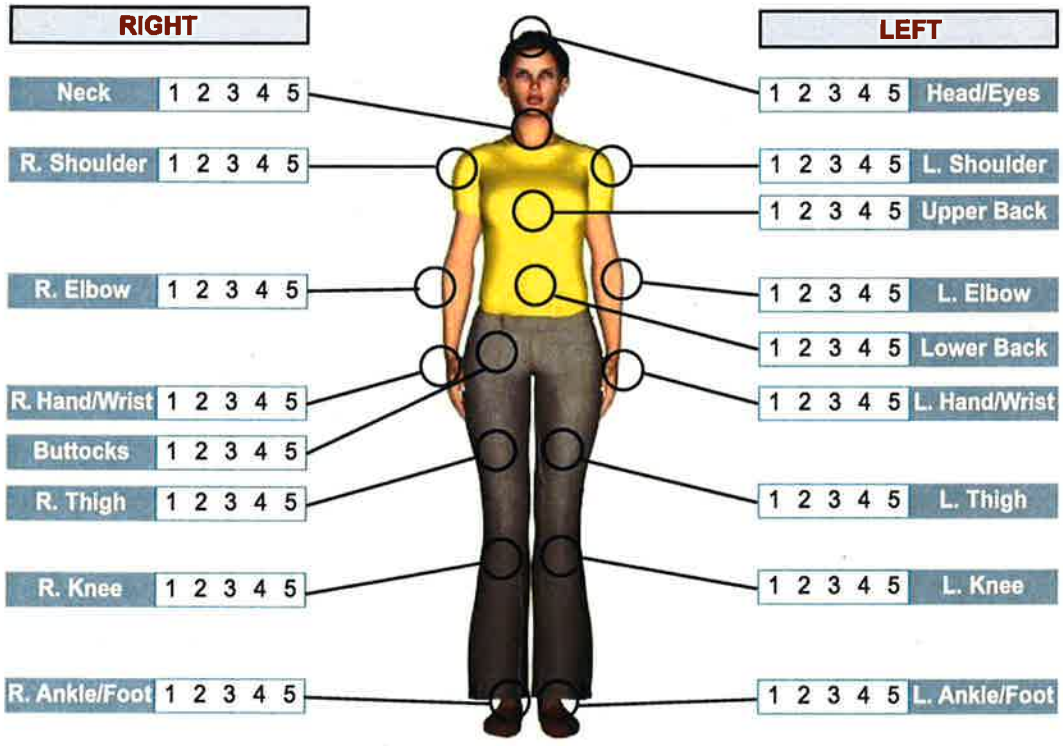
## WHAT YOU DO

Department _____ Date _____
Job _____ Gender M F
Supervisor _____ Age (years) _____
Shift 1 2 3 Other: How long have you worked for this company? _____

## HOW YOU FEEL

Do you experience musculoskeletal discomfort that you feel is related to your work tasks?
**YES** (*If yes, please complete the discomfort chart below*) **NO** (*If no, skip to "tell us about your job" section*)

*For any body part having discomfort, circle the number that ranks the discomfort level. 1=some discomfort, 2, 3, 4, 5=very uncomfortable*




## FOR THE AREA OF MOST DISCOMFORT, ANSWER THE FOLLOWING (CIRCLE #):

Which body part has the highest discomfort and is of most concern to you? _____

A. How long has it been since you started to experience the discomfort?

1– days
2– weeks
3– months
4– years

B. How often do you experience the discomfort?

1– always, constantly
2– occasionally
3– at rest
4– when active

C. How did the discomfort start?

1– gradually, over time
2– suddenly
3– injury/accident

## TELL US ABOUT YOUR JOB

***Circle the specific part of your job that is of concern to you.***

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Workplace** | no concern | chair | desk | office layout | adjustability | heights | reaches | flooring |
| **Work/Job** | no concern | tasks | breaks | pace | deadlines | variety | | |
| **Office Tools** | no concern | size | shape | function correctly | ease of use | location | compatibility | |
| **Materials Handling** | no concern | lifting | weight | push/pull | carrying | frequency | | |
| **Environment** | no concern | temperature | ventilation | lighting | noise | vibration | | |

## YOUR THOUGHTS

What do you think would make your job easier? _____

If you have specific concerns about your job, write them here. _____

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