Employee Musculoskeletal Discomfort Report (Non-office)

yorku.ca/ergo

Revised 2013-Dec-2

Name: Employee Group/Union: Date:

Month/year you started working at York? Month/year you started working at your current location?

Dominant Hand? Right☐, Left☐ Height: Do you wear: glasses ☐, contact lenses ☐, bifocals ☐, multifocals ☐

Do you believe your discomfort is due to a work-related injury? Yes No notSure
(If Yes, let your supervisor know since a Supervisor's Accident Investigation Report may need to be completed.)

Have you discussed your discomfort with a health care practitioner? Yes No

Have you missed work because of your discomfort? Yes No

Select all that apply: ☐pain ☐stiffness/tightness ☐weakness ☐redness ☐swelling ☐tingling/numbness

	Head/Eyes	Neck/Shoulders	Arms/Hands	Low Back	Legs/Feet
1) Are you currently experiencing discomfort in this body part?	Yes No If yes, complete remainder of column	Yes No If yes, complete remainder of column	Yes No If yes, complete remainder of column	Yes No If yes, complete remainder of column	Yes No If yes, complete remainder of column
2) Where is your discomfort?	☐head ☐eyes	☐right side ☐left side ☐middle	☐right ☐left	☐right side ☐left side ☐middle	☐right ☐left
3) When did you 1st notice this discomfort?	Date:	Date:	Date:	Date:	Date:
4) Rate your discomfort at the following times (0=no discomfort, 3 = unbearable pain)					
Before work	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
During work	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
After work	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
After a few days away from work	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3

1. What work and home activities cause the greatest discomfort?

2. Are there any trends to your discomfort (i.e. worse at certain times of the day, certain days of the week, certain times of the year, etc)? If yes, please explain:

3. Was there a single event or series of events that preceded the first time you noticed your discomfort? If yes, please explain:

4. What changes have you tried that REDUCED the discomfort?

5. What changes have you tried that HAD NO EFFECT ON the discomfort?

6. In your opinion, what further changes would reduce the discomfort? For more ideas, complete an Activity Improvement Tool for each activity you mentioned in #1 above.

Activity Improvement Tool

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Revised 2013-Dec-13

Supervisor: Worker: Date:

Activity: Difficulty: ☐ some difficulty ☐ moderate difficulty ☐ almost impossible

Describe the difficulty and possible improvements using the checkboxes (check all that apply) and space below.

1) Possible physical demand(s)	2) Possible contributing factors or areas for improvement	3) Additional details about the difficulty (e.g. what part of the activity causes the difficulty)	4) What improvements could be considered?
☐ duration/ repetitiveness of the activity ☐ weight of item handled ☐ amount of force required ☐ awkward grip ☐ awkward/ static posture ☐ awkward movement ☐ vibration/ impact ☐ other	☐ ask for help[1] ☐ body mechanics, work method, procedure compliance[2] ☐ type of materials handled ☐ maintenance of tools/equipment ☐ availability of tools/equipment ☐ design/quality of tools/equipment ☐ work area ☐ storage area ☐ actions of others ☐ other		

[1]indicate barriers and how getting help could be made easier, [2]see Procedure Compliance Tool

Use additional pages if necessary