

**Ergonomic Questionnaire**

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| --- | --- |
| **Name:** |  |
| **Department:** |  |
| **Office/Workstation Location:** |  |
| **Email:** |  |
| **Phone Extension:** |  |

**Do you have concerns you would like to have addressed? Or would like to check to make sure you’re set up properly?** Choose an item.

**Are there changes/adjustments that you think will help you?** [ ] Yes [ ]  No

**Workstation component(s) you would like to have evaluated**

[ ]  Chair

[ ]  Keyboard/Mouse

[ ]  Computer Monitor

[ ]  Telephone

|  |
| --- |
|  |

[ ]  Other:

**Have you been trained how to adjust your chair to its proper position?** [ ]  Yes [ ]  No

 **If no, would you like training on the adjustments?** [ ]  Yes [ ]  No

**Indicate number of hours you spend each day doing the following tasks**

***(\*Total hours may exceed hours worked in a day as you can perform some of these tasks simultaneously)***

Computer use: Choose an item.

Phone use: Choose an item.

Sitting: Choose an item.

Standing: Choose an item.

Lifting/bending/twisting: Choose an item.

**Do you take routine breaks throughout the day? (rest eyes every twenty minutes, stand up every hour)**

Choose an item.

**Do you refer to paper documents while working on the computer? If so, do you use a document holder?**

[ ]  Yes, and use document holder

[ ]  Yes, but do not use document holder

[ ]  No, do not refer to documents while completing computer work

**Eyewear**

[ ]  None [ ]  Standard Glasses

[ ]  Contacts [ ]  Bifocals/Trifocals

**Do you experience any of the following?**

[ ]  Dry eyes [ ]  Eyestrain

[ ]  Watery eyes [ ]  Blurred Vision

[ ]  Headaches [ ]  Itchy eyes

**During the last work week, how frequent was your discomfort?**

Choose an item.

**Indicate areas and levels of discomfort (1 = no pain, 5 = increased pain)**

Neck/Shoulders: [ ]  1 [ ]  2 [ ]  3 [ ]  4 [ ]  5

Mid back: [ ]  1 [ ]  2 [ ]  3 [ ]  4 [ ]  5

Lower back: [ ]  1 [ ]  2 [ ]  3 [ ]  4 [ ]  5

Elbow(s): [ ]  1 [ ]  2 [ ]  3 [ ]  4 [ ]  5

Wrist(s)/hand(s): [ ]  1 [ ]  2 [ ]  3 [ ]  4 [ ]  5

Hip(s): [ ]  1 [ ]  2 [ ]  3 [ ]  4 [ ]  5

Legs(s): [ ]  1 [ ]  2 [ ]  3 [ ]  4 [ ]  5

Knee(s): [ ]  1 [ ]  2 [ ]  3 [ ]  4 [ ]  5

Foot/Ankle(s) [ ]  1 [ ]  2 [ ]  3 [ ]  4 [ ]  5

**During the last work week, how frequent was your discomfort?**

Choose an item.

**Laptop Usage:**

Laptop used for work: [ ]  Yes [ ]  No

If yes, laptop stand used: [ ]  Yes [ ]  No

If yes, external keyboard/mouse used: [ ]  Yes [ ]  No

**Additional Comments/Concerns:**