Ergonomics Comfort Level Survey

Name: ______________________________ Line/Area: ______________________

Date: __________________

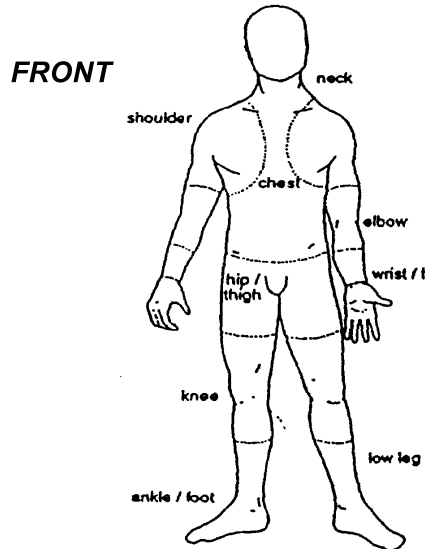
Jobs/Tasks in your typical rotation/shift: 1.__________________ 2.________________________
3.__________________ 4.________________________

Do you have any pain or discomfort that you believe to be related to your work?
☐ Yes ☐ No

If YES, please circle the Job/Task (from your list above) that you feel contributes the most to your discomfort.
MARK an "X" on the drawings and indicate the related level of discomfort in the blank area, based on the scale below.

LEFT SIDE	
Head/Neck	_______
Shoulder	_______
Chest	_______
Elbow	_______
Hand/Wrist	_______
Hip/Thigh	_______
Knee	_______
Lower Leg	_______
Ankle/Foot	_______
Other	_______

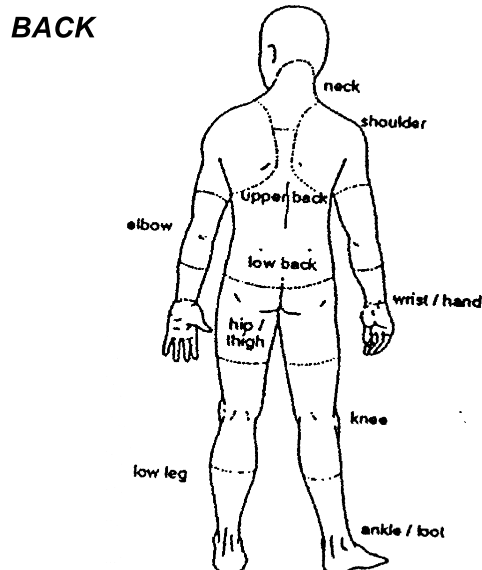
FRONT



RIGHT SIDE	
Head/Neck	_______
Shoulder	_______
Chest	_______
Elbow	_______
Hand/Wrist	_______
Hip/Thigh	_______
Knee	_______
Lower Leg	_______
Ankle/Foot	_______
Other	_______

LEFT SIDE	
Shoulder	_______
Upper Arm	_______
Elbow	_______
Hand/Wrist	_______
Buttock	_______
Thigh	_______
Knee	_______
Lower Leg	_______
Ankle/Foot	_______
Other	_______

BACK



RIGHT SIDE	
Shoulder	_______
Upper Arm	_______
Elbow	_______
Hand/Wrist	_______
Buttock	_______
Thigh	_______
Knee	_______
Lower Leg	_______
Ankle/Foot	_______
Other	_______

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