

SELF-REPORT OF PAIN AND DISCOMFORT

Employee Name:

Date:

For each body part, describe how your current pain or discomfort, and indicate the intensity.

Neck	
How Often?	How Much?
<input type="checkbox"/> Never	<input type="checkbox"/> No Discomfort
<input type="checkbox"/> Occasionally	<input type="checkbox"/> Discomfort
<input type="checkbox"/> Frequently	<input type="checkbox"/> Pain
<input type="checkbox"/> Constantly	<input type="checkbox"/> Severe Pain

Upper Back	
How Often?	How Much?
<input type="checkbox"/> Never	<input type="checkbox"/> No Discomfort
<input type="checkbox"/> Occasionally	<input type="checkbox"/> Discomfort
<input type="checkbox"/> Frequently	<input type="checkbox"/> Pain
<input type="checkbox"/> Constantly	<input type="checkbox"/> Severe Pain

Shoulders (R/L)	
<input type="checkbox"/> Never	<input type="checkbox"/> No Discomfort
<input type="checkbox"/> Occasionally	<input type="checkbox"/> Discomfort
<input type="checkbox"/> Frequently	<input type="checkbox"/> Pain
<input type="checkbox"/> Constantly	<input type="checkbox"/> Severe Pain

Lower Back	
<input type="checkbox"/> Never	<input type="checkbox"/> No Discomfort
<input type="checkbox"/> Occasionally	<input type="checkbox"/> Discomfort
<input type="checkbox"/> Frequently	<input type="checkbox"/> Pain
<input type="checkbox"/> Constantly	<input type="checkbox"/> Severe Pain

Elbows (R/L)	
<input type="checkbox"/> Never	<input type="checkbox"/> No Discomfort
<input type="checkbox"/> Occasionally	<input type="checkbox"/> Discomfort
<input type="checkbox"/> Frequently	<input type="checkbox"/> Pain
<input type="checkbox"/> Constantly	<input type="checkbox"/> Severe Pain

Hips/Legs (R/L)	
<input type="checkbox"/> Never	<input type="checkbox"/> No Discomfort
<input type="checkbox"/> Occasionally	<input type="checkbox"/> Discomfort
<input type="checkbox"/> Frequently	<input type="checkbox"/> Pain
<input type="checkbox"/> Constantly	<input type="checkbox"/> Severe Pain

Forearms (R/L)	
<input type="checkbox"/> Never	<input type="checkbox"/> No Discomfort
<input type="checkbox"/> Occasionally	<input type="checkbox"/> Discomfort
<input type="checkbox"/> Frequently	<input type="checkbox"/> Pain
<input type="checkbox"/> Constantly	<input type="checkbox"/> Severe Pain

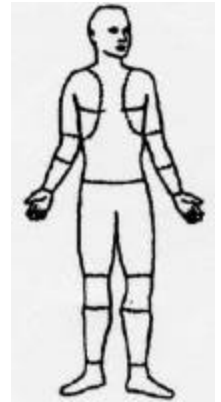
Knees (R/L)	
<input type="checkbox"/> Never	<input type="checkbox"/> No Discomfort
<input type="checkbox"/> Occasionally	<input type="checkbox"/> Discomfort
<input type="checkbox"/> Frequently	<input type="checkbox"/> Pain
<input type="checkbox"/> Constantly	<input type="checkbox"/> Severe Pain

Wrists (R/L)	
<input type="checkbox"/> Never	<input type="checkbox"/> No Discomfort
<input type="checkbox"/> Occasionally	<input type="checkbox"/> Discomfort
<input type="checkbox"/> Frequently	<input type="checkbox"/> Pain
<input type="checkbox"/> Constantly	<input type="checkbox"/> Severe Pain

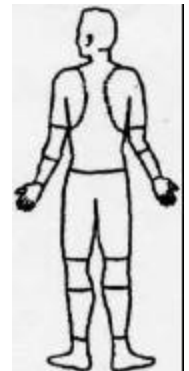
Ankles/Feet (R/L)	
<input type="checkbox"/> Never	<input type="checkbox"/> No Discomfort
<input type="checkbox"/> Occasionally	<input type="checkbox"/> Discomfort
<input type="checkbox"/> Frequently	<input type="checkbox"/> Pain
<input type="checkbox"/> Constantly	<input type="checkbox"/> Severe Pain

Hands (R/L)	
<input type="checkbox"/> Never	<input type="checkbox"/> No Discomfort
<input type="checkbox"/> Occasionally	<input type="checkbox"/> Discomfort
<input type="checkbox"/> Frequently	<input type="checkbox"/> Pain
<input type="checkbox"/> Constantly	<input type="checkbox"/> Severe Pain

Eyes (Dry / Sore / Blurred)	
<input type="checkbox"/> Never	<input type="checkbox"/> No Discomfort
<input type="checkbox"/> Occasionally	<input type="checkbox"/> Discomfort
<input type="checkbox"/> Frequently	<input type="checkbox"/> Pain
<input type="checkbox"/> Constantly	<input type="checkbox"/> Severe Pain



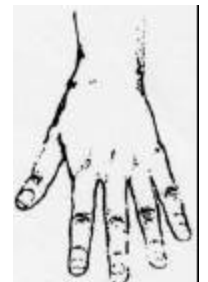
Front
Back



Onset of Symptoms:

Current Medications/Treatments:

Previous Medical History:



Front