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?
☐ Never	☐ No Discomfort
☐ Occasionally	☐ Discomfort
☐ Frequently	☐ Pain
☐ Constantly	☐ Severe Pain

Shoulders (R/L)	
☐ Never	☐ No Discomfort
☐ Occasionally	☐ Discomfort
☐ Frequently	☐ Pain
☐ Constantly	☐ Severe Pain

Elbows (R/L)	
☐ Never	☐ No Discomfort
☐ Occasionally	☐ Discomfort
☐ Frequently	☐ Pain
☐ Constantly	☐ Severe Pain

Forearms (R/L)	
☐ Never	☐ No Discomfort
☐ Occasionally	☐ Discomfort
☐ Frequently	☐ Pain
☐ Constantly	☐ Severe Pain

Wrists (R/L)	
☐ Never	☐ No Discomfort
☐ Occasionally	☐ Discomfort
☐ Frequently	☐ Pain
☐ Constantly	☐ Severe Pain

Hands (R/L)	
☐ Never	☐ No Discomfort
☐ Occasionally	☐ Discomfort
☐ Frequently	☐ Pain
☐ Constantly	☐ Severe Pain

Upper Back	
How Often?	How Much?
☐ Never	☐ No Discomfort
☐ Occasionally	☐ Discomfort
☐ Frequently	☐ Pain
☐ Constantly	☐ Severe Pain

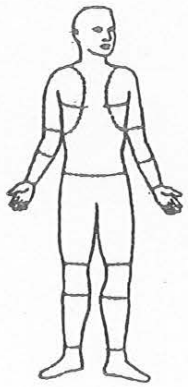
Lower Back	
☐ Never	☐ No Discomfort
☐ Occasionally	☐ Discomfort
☐ Frequently	☐ Pain
☐ Constantly	☐ Severe Pain

Hips/Legs (R/L)	
☐ Never	☐ No Discomfort
☐ Occasionally	☐ Discomfort
☐ Frequently	☐ Pain
☐ Constantly	☐ Severe Pain

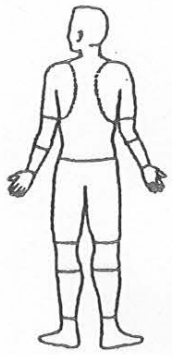
Knees (R/L)	
☐ Never	☐ No Discomfort
☐ Occasionally	☐ Discomfort
☐ Frequently	☐ Pain
☐ Constantly	☐ Severe Pain

Ankles/Feet (R/L)	
☐ Never	☐ No Discomfort
☐ Occasionally	☐ Discomfort
☐ Frequently	☐ Pain
☐ Constantly	☐ Severe Pain

Eyes (Dry / Sore / Blurred)	
☐ Never	☐ No Discomfort
☐ Occasionally	☐ Discomfort
☐ Frequently	☐ Pain
☐ Constantly	☐ Severe Pain



Front



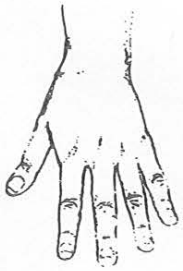
Back

Onset of Symptoms:

Current Medications/Treatments:

Previous Medical History:

Front



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