OCCUPATIONAL DISCOMFORT SURVEY

NAME	EMPLOYEE NUMBER	LOCATION	JOB CATEGORY

We are instituting an occupational discomfort survey in an effort to exceed our employee health and safety goals.

Complete this survey at the end of your daily shift.

Please be candid in your selection.

This visual pain perception scale lets you rate pain and discomfort from 1 to 10 (10 being the worst pain).
(Circling a '6' says "mild pain".)
Write your pain level number in the pain score box.
Total the pain score boxes.

	0 Absolutely no pain	1	2 Mild pain	3	4 Moderate Pain	5	6 Very Uncomfortable	7	8 Severe Pain	9	10 Horrible Pain	Pain Score
Foot Pain	Circle the number that represents your pain level at the end of the day.						Write that number in the Pain Score Box.					
Knee Pain	Circle the number that represents your pain level at the end of the day.						Write that number in the Pain Score Box.					
Leg Pain	Circle the number that represents your pain level at the end of the day.						Write that number in the Pain Score Box.					
Back Pain	Circle the number that represents your pain level at the end of the day.						Write that number in the Pain Score Box.					
Headache	Circle the number that represents your pain level at the end of the day.						Write that number in the Pain Score Box.					

TOTAL PAIN SCORE	

NOTES:

List any devices that you may be using to reduce occupational discomfort or pain?

(Consumer Insoles, Mats, Special Shoes, etc)

Suggestions: