

Date \_\_\_/\_\_\_/\_\_\_

### Symptom Survey

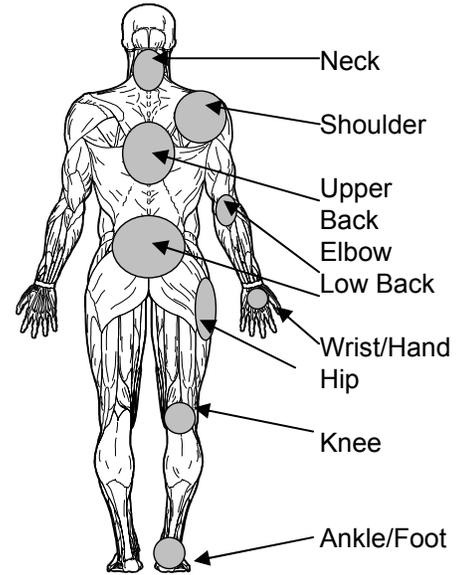
Age \_\_\_yrs      Height \_\_\_ feet \_\_\_ inches      Weight \_\_\_ lbs

Male       Female

How long have you worked at your present job? \_\_\_years \_\_\_months

Job type: Please check your job category:     RN     LPN     CNA     Other

On the diagram to the right please circle any areas where you feel have felt pain or discomfort recently. 



**Please check yes or no for ALL questions below:**

During the last 12 months have you had a **job-related** ache, pain, discomfort, etc in:

NECK      No \_\_\_ Yes \_\_\_  
 UPPER BACK      No \_\_\_ Yes \_\_\_  
 LOW BACK      No \_\_\_ Yes \_\_\_

SHOULDERS      No \_\_\_ Yes \_\_\_  
 ELBOWS      No \_\_\_ Yes \_\_\_  
 WRIST/HAND      No \_\_\_ Yes \_\_\_

HIPS/THIGHS      No \_\_\_ Yes \_\_\_  
 KNEES      No \_\_\_ Yes \_\_\_  
 FEET      No \_\_\_ Yes \_\_\_

During the last 12 months have you been **prevented from doing your day's work** due to this condition?

No \_\_\_ Yes \_\_\_  
 No \_\_\_ Yes \_\_\_  
 No \_\_\_ Yes \_\_\_

No \_\_\_ Yes \_\_\_  
 No \_\_\_ Yes \_\_\_  
 No \_\_\_ Yes \_\_\_

No \_\_\_ Yes \_\_\_  
 No \_\_\_ Yes \_\_\_  
 No \_\_\_ Yes \_\_\_

During the last 12 months have you **seen a physician** (M.D., Osteopath, Chiropractor) for this condition?

No \_\_\_ Yes \_\_\_  
 No \_\_\_ Yes \_\_\_  
 No \_\_\_ Yes \_\_\_

No \_\_\_ Yes \_\_\_  
 No \_\_\_ Yes \_\_\_  
 No \_\_\_ Yes \_\_\_

No \_\_\_ Yes \_\_\_  
 No \_\_\_ Yes \_\_\_  
 No \_\_\_ Yes \_\_\_

**Please answer the following questions by circling the answer:**

1. Please rate your overall back pain

0      1      2      3      4      5      6      7      8      9      10  
 Comfortable      Uncomfortable

2. Please rate any **back pain** you typically experience at the end of a typical work day

0      1      2      3      4      5      6      7      8      9      10  
 Pain Free      Extreme pain

3. In the past 12 months have you had an injury related to resident handling?

\_\_\_ Yes      \_\_\_ No

4. If you have had an injury related to resident handling about how many days of work did you miss?

\_\_\_ 0      \_\_\_ 1-4      \_\_\_ 5-10      \_\_\_ more than 10