

Musculoskeletal Discomfort Form

(Based on the Nordic Questionnaire (Kourinka et al. 1987))

Employee ID: _____

Job/Position: _____

Gender: M F Age: _____

Height: ____ ft. ____ in.

Weight: _____

How long have you been doing this job? ____ years ____ months

How many hours do you work each week? _____

How to answer the questionnaire:

Picture: In this picture you can see the approximate position of the parts of the body referred to in the table. Limits are not sharply defined, and certain parts overlap. You should decide for yourself in which part you have or have had your trouble (if any).

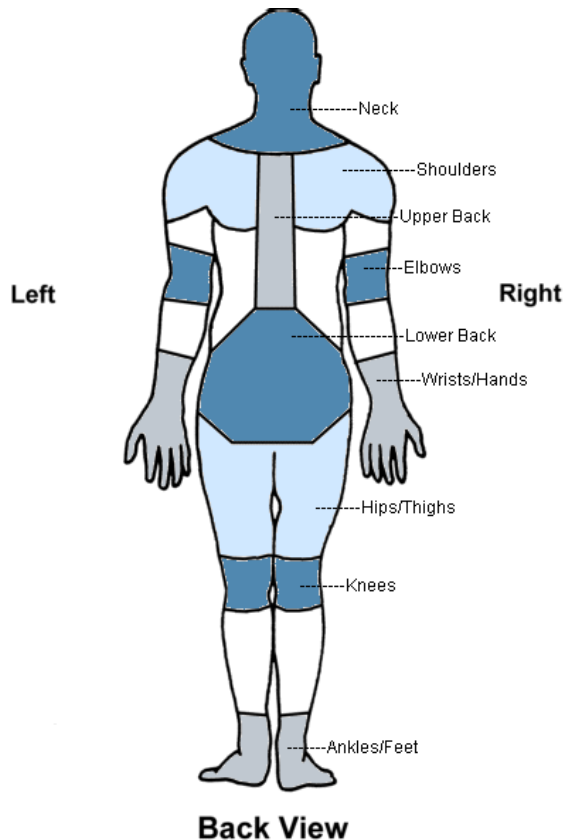


Table: Please answer by putting an "X" in the appropriate box - one "X" for each question. You may be in doubt as to how to answer, but please do your best anyway. Note that column 1 of the questionnaire is to be answered even if you have never had trouble in any part of your body; columns 2 and 3 are to be answered if you answered yes in column 1.

To be answered by everyone	To be answered by those who have had trouble	
Have you at any time during the last 12 months had trouble (ache, pain, discomfort, numbness) in:	Have you at any time during the last 12 months been prevented from doing your normal work (at home or away from home) because of the trouble?	Have you had trouble at any time during the last 7 days?
Neck <input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Shoulders <input type="checkbox"/> No <input type="checkbox"/> Yes, right shoulder <input type="checkbox"/> Yes, left shoulder <input type="checkbox"/> Yes, both shoulders	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Elbows <input type="checkbox"/> No <input type="checkbox"/> Yes, right elbow <input type="checkbox"/> Yes, left elbow <input type="checkbox"/> Yes, both elbows	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Wrists/Hands <input type="checkbox"/> No <input type="checkbox"/> Yes, right wrist/hand <input type="checkbox"/> Yes, left wrist/hand <input type="checkbox"/> Yes, both wrists/hands	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Upper Back <input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Lower Back (small of back) <input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
One or Both Hips/Thighs <input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
One or Both Knees <input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
One or Both Ankles/Feet <input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes