**Office Ergonomics Pre-Assessment Survey**
*(This form must be completed before appointments can be booked.)*

<table>
<thead>
<tr>
<th>Name:</th>
<th>Department:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Email:</td>
<td>Position:</td>
<td>Building and Room #:</td>
</tr>
<tr>
<td>Phone Extension:</td>
<td>Union group/ Ee:</td>
<td>Supervisor:</td>
</tr>
</tbody>
</table>

**Typical work hours per day:** _________ hrs.  **Total break time per day:** _________ mins.

<table>
<thead>
<tr>
<th>Typical Duties</th>
<th>Time per day</th>
<th>Provide Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Computer Work</td>
<td>mins. / hrs. (i.e. programs used):</td>
<td></td>
</tr>
<tr>
<td>Paperwork</td>
<td>mins. / hrs. (i.e. edit, read, write reports):</td>
<td></td>
</tr>
<tr>
<td>Meetings</td>
<td>mins. / hrs. (i.e. keep minutes, speaker):</td>
<td></td>
</tr>
<tr>
<td>Filing / Sorting</td>
<td>mins. / hrs. (i.e. drawer heights):</td>
<td></td>
</tr>
<tr>
<td>Telephone</td>
<td>mins. / hrs. (i.e. % using both phone and computer):</td>
<td></td>
</tr>
<tr>
<td>Photocopying</td>
<td>mins. / hrs. (i.e. walking distance to machine, frequency)</td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td>mins. / hrs. (i.e. teaching):</td>
<td></td>
</tr>
</tbody>
</table>

Please indicate the percent of time spent using the following computer input methods each day:

Mouse: ______%  Letter keys: ______%  Number Keys (Pad): ______%  Secondary Functions (i.e. F2, Tab): ______%

What percentage of the day involves interacting with the computer independently (i.e. email)? _____%

How often do you combine computer work with reading paper work (i.e. transcribing, researching)? _____%

How often do you combine computer work with writing paper work (i.e. editing paperwork)? _____%

What percentage of the day involves using the telephone while writing messages or using the computer? _____%

What software do you use most frequently (i.e. Peoplesoft, email etc.)?

Do you use a laptop for work?  ☐ Yes  ☐ No

What kind of carrying case do you use to transport the laptop?  ☐ Roller case  ☐ Single shoulder strap  ☐ Backpack

How long do you typically sit at your workstation at one time without standing? _________ mins. / hrs.

**Visual Information:**

Corrective lenses:  ☐ None  ☐ Single lens glasses  ☐ Bi / Tri-focals / Progressive  ☐ Contact lenses

If you wear bi / tri-focals what part of the lens do you look through:

i) To view the computer screen?  ☐ Bottom  ☐ Middle  ☐ Top  ☐ N/A

ii) To read paper documents?  ☐ Bottom  ☐ Middle  ☐ Top  ☐ N/A

iii) When speaking with people?  ☐ Bottom  ☐ Middle  ☐ Top  ☐ N/A
Using the following picture please circle the area(s) in which you currently experience symptoms (if any) while performing your work tasks.

Pain or discomfort:  
- slight ☐  
- moderate ☐  
- significant ☐  
- severe ☐

Are you currently receiving treatment(s) for your discomfort? ☐ Yes ☐ No

If yes, please indicate what types of treatment(s) you have been receiving:

If you have ever reported an accident or incident (AIIR) related to your current work duties please describe and include date:

Are you currently involved with Rehabilitation Services for this discomfort? If so, please describe:

Have you had a previous office ergonomics assessment? If so, please describe and include date:

Is this assessment a preventative measure ☐ or related to a specific concern ☐?

Did you complete the self-help section on the website? ☐ Yes ☐ No

Please discuss your request for an ergonomic assessment with your supervisor? Completed: ☐ Yes ☐ No

Further Comments:

Employee Signature:_____________________________________     Date:______________

Please return form to:   Ergonomic Services       SSB 4159