Western University
MSD Prevention Program
Worker Discomfort Survey - Form 1B

The worker is asked to rate their level of discomfort for each body region by numbering their pain on a scale from 0-10. A score of 0 indicates no discomfort while a score of 10 indicates the worst discomfort ever experienced. All workers who perform a job should take part in the survey. For further information visit the Western Ergonomics website.

Date: ___________________  Job: ___________________  Area: ___________________

Hours worked/week : ___________________  Time on THIS Job: _____ Years  _____ Months

1. Have you had pain or discomfort during the last year?
   [   ] Yes  [   ] No (if NO, Stop here)

2. If YES, please rate the level of discomfort over the last MONTH by completing the ‘how much?’ box using the scale of 0 to 10, with 0 being no discomfort and 10 being the worst discomfort ever.
If you are a recent hire, please list other jobs you have done in the last year (for more than 2 weeks)

**Note:** If more than 2 jobs, only include those you worked on the most

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<th>Job</th>
<th>Time on THIS Job (months) (weeks)</th>
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3. When did you first notice your discomfort? _________ (month) _________ (year)

4. What do you think caused the discomfort? Is it a specific task?

5. Please comment on what you think would help to reduce your level of discomfort. Any changes or recommendations you would make to the work environment to reduce risk of injury?

6. Do you consider your discomfort to be a problem?

   ☐ Yes  ☐ No

7. Have you have missed time from work (vacation, sick days,) or attended medical review as a result of your work related discomfort?

   ☐ Yes  ☐ No

If yes, and you have not already completed an Accident/Incident Report, you are required to notify your supervisor to follow the reporting process.