

Employee Comfort Survey

Do you experience discomfort, numbness, or pain in any part of your body while at work or when you go home? For each body part listed, check the frequency of discomfort.

Department
Job
Date

Shoulders
<input type="checkbox"/> Never <input type="checkbox"/> Occasionally <input type="checkbox"/> Often <input type="checkbox"/> Always

Neck
<input type="checkbox"/> Never <input type="checkbox"/> Occasionally <input type="checkbox"/> Often <input type="checkbox"/> Always

Eye Strain
<input type="checkbox"/> Never <input type="checkbox"/> Occasionally <input type="checkbox"/> Often <input type="checkbox"/> Always

Dry/Sore Eyes
<input type="checkbox"/> Never <input type="checkbox"/> Occasionally <input type="checkbox"/> Often <input type="checkbox"/> Always

Upper Back
<input type="checkbox"/> Never <input type="checkbox"/> Occasionally <input type="checkbox"/> Often <input type="checkbox"/> Always

Blurred Vision
<input type="checkbox"/> Never <input type="checkbox"/> Occasionally <input type="checkbox"/> Often <input type="checkbox"/> Always

Forearm
<input type="checkbox"/> Never <input type="checkbox"/> Occasionally <input type="checkbox"/> Often <input type="checkbox"/> Always



Wrist/Hand
<input type="checkbox"/> Never <input type="checkbox"/> Occasionally <input type="checkbox"/> Often <input type="checkbox"/> Always

Elbows
<input type="checkbox"/> Never <input type="checkbox"/> Occasionally <input type="checkbox"/> Often <input type="checkbox"/> Always

Knees
<input type="checkbox"/> Never <input type="checkbox"/> Occasionally <input type="checkbox"/> Often <input type="checkbox"/> Always

Hip
<input type="checkbox"/> Never <input type="checkbox"/> Occasionally <input type="checkbox"/> Often <input type="checkbox"/> Always

Lower Body
<input type="checkbox"/> Never <input type="checkbox"/> Occasionally <input type="checkbox"/> Often <input type="checkbox"/> Always