Ergonomics Inspection Worksheet

Cal/OSHA – Oakland District Office

Version: 3/11/99

Section 1: Symptoms Questionnaire
(All medical information obtained in this section will be kept confidential)

Please check the words that best describe your injury:

___ Pain	___ Throbbing	___ Sweating
___ Numbness	___ Swelling	___ Stiffness
___ Loss of color	___ Tingling	___ Weakness
___ Cramping	___ Burning	___ Redness

___ Other symptoms: _____

1. When did you first notice the problem? _____ (month) _____ (year)
2. What do you think caused the problem? _____
3. Have you had this problem in the last seven days? ____ Yes ____ No
4. How long does/did the pain last after the work day?

   Now: ____ 1-3 hours ____ Overnight _____ 1 week ____ Continuous

   Then: ____ 1-3 hours ____ Overnight _____ 1 week ____ Continuous

5. How many times have you this problem in the last year? _____
6. How would you describe the pain?

Now	When worst	
5	5	Pain is unbearable
4	4	Very bad pain
3	3	Moderate pain
2	2	Little pain
1	1	No pain at all

7. Have you had medical treatment for this problem? ___ Yes ___ No

___ plant medical	Times in last year _____
___ personal doctor	Times in last year _____
___ chiropractor	Times in last year _____
___ Other	Times in last year _____

8. What was the diagnosis? _____

   Doctor making diagnosis: _____
   Date of diagnosis: _____

9. What type of treatment did you receive?

   - medications: _____

   - physical therapy: _____
     Type: _____
     How often/how long: _____

   - splints: _____
     Type: _____
     How long in use: _____

   - surgery: _____
     When: _____
     What operation: _____

10. Did the treatment help? _____

12. Have you lost any time in the last year? ___ Yes ___No
    How many days? _____

13. Have you been on restricted or modified work? ___ Yes ___ No

    What restrictions: _____
    How long: _____

14. Was a workers comp claim filed: ___ Yes ___ No

15. Do you know the names of co-workers who have had ergonomic injuries (hand, wrist, elbow, arm, shoulder, neck, back)?

    Name: _____
    Name: _____
    Name: _____
    Name: _____

16. Repetitive motion activities away from work:

    Sports: _____ Hours per week: _____
    Hobbies: _____ Hours per week: _____
    Home computer: _____ Hours per week: _____

Power tools: _____ Hours per week: _____
Musical instruments: _____ Hours per week: _____
Other activities: _____ Hours per week: _____

Section 2: Work Activities

17. How much time performing following computer-related tasks on daily basis:

Keying: _____(hours)
Mouse: _____(hours)
Number pad entry: _____(hours)
Other VDT tasks: _____(hours)

18. How much time performing non-computer tasks:

Activity: _____(hours)
Activity: _____(hours)
Activity: _____(hours)

19. How much time answering telephone: _____(hours)
Headset: ___ Yes ___ No

20. How much time sitting versus standing in approximate percentage:

Sitting: _____%
Standing: _____%

21. Describe break schedule:

AM: number: _____ minutes: _____
Lunch: _____minutes
PM: number: _____ minutes: _____

22. Are the same tasks rotated among co-workers: ___ Yes ___ No

How long is the rotation: _____(hours)

Section 3: Ergo Program Implementation

23. Have there been any pre-injury work station evaluations?

By whom: _____
When: _____
Record/checklist used: _____
Employee informed of results: ___ Yes ___ No

24. Have there been any post-injury work station evaluations?

By whom: _____
When: _____
Record/checklist used: _____
Employee informed of results: ___ Yes ___ No

25. What adjustments/controls have implemented since evaluation(s):

What action: _____
When: _____
Who implemented: _____

26. What administrative controls implemented:

More frequent breaks: ___ Yes ___ No Schedule: _____
Scheduled exercises: ___ Yes ___ No Schedule: _____
Job rotation: ____ Yes ___ No Schedule: _____

27. Employee training topics:

Employer's program: Yes No

Exposures associated with RMIs: Yes No

Symptoms and injury consequences: Yes No

Importance of reporting: Yes No

ER methods to minimize RMIs: Yes No

How to request an evaluation: Yes No

How to adjust equipment: Yes No

Ergonomic exercises: Yes No

Question and answer period: Yes No

28. Classroom/meeting training: ___ Yes ___ No

Last class date: _____ No. of previous: _____
Instructor: _____
Length of class: _____

29. One-on-one instruction: ___ Yes ___No

Last session date: _____ No. of previous: _____
Instructor: _____
Length of session: _____
Injury-related: Yes No

Section 4: Work Station Parameters

30. Chair: Is height adjustable while seated: Yes No
Is backrest height adjustable: Yes No
Is backrest angle adjustable: Yes No
Are forearm/elbow rests adjustable: Yes No
Are forearm/elbow rest removable: Yes No
Is the chair cramped at back/either side: Yes No

31. Floor: Is there adequate leg room: Yes No
Are foot rests available: Yes No
Is the footrest in use: Yes No

32. Desktop: Is there adequate work surface: Yes No
Are table edges padded or rounded: Yes No
Desk/work surface height: _____ inches
Documents at: left front right
Document holder: available in use not available
Distance between task and screen: _____ inches
Telephone location: within reach stretch
Telephone headset: Yes No
Adequate lighting of work surface Yes No

33. Keyboard: Location: on desktop adjustable/detached platform
Platform height: _____ inches
Mouse: within reach stretch
Wrist pad: Yes No
Wrist position: neutral flexed extended

34. Monitor: Location: left straight right
Monitor level with eyes: below level above
Eye distance to screen: _____ inches
Height adjustable: Yes No
Angle adjustable: Yes No
Glare problem for operator: Yes No
Glare shield on monitor: Yes No
Screen flicker problem: Yes No